

EXPERIENCES OF WOMEN SURVIVORS OF SEXUAL VIOLENCE IN
SEEKING MEDICALCARE IN KIBAHA DISTRICT, COAST REGION,
TANZANIA

BY

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DECLARATION

This project paper is my original work and has not been submitted for examination in any other university.

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Dr. Owuor Olungah

DEDICATION

This work is dedicated to my late mom, Fatma Mganga, for her tireless efforts in ensuring I achieved the best in my studies. Without you, I wouldn't have reached this far. May our Almighty God rest your good soul in eternal peace.

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LIST OF ABBREVIATIONS AND ACRONYMS

CDO	Community Development Officer
CEDAW	Convention on the Elimination of All Forms against Women
COSTECH	Commission for Science and Technology Tanzania
CSA	Child Sexual Abuse,
DDH	District designated Hospital (DDH),
FBO	Faith Based Organization
FGD	Focus Group Discussion
FHI	Family Health International
HDT	Human Development Trust
HIV	Human immune-Deficiency Virus
HSSP	Health Sector Strategic Plan
KDC	Kibaha District Council
KIKODET	Kifaru Community Development in Tanzania
KNBS	Kenya Demographic and Health Survey
MCDGC	Ministry of Community Development, Gender and Children
MKUKUTA	Mkakati wa Kukuza Uchumi na Kuondoa Umasikini Tanzania
MoHSW	Ministry of Health and Social Welfare
MRCC	Medical Research Coordinating Committee
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NOLA	National Organization for Legal Assistance
NSGD	National Strategy for Gender Development

PEP	Post Exposure Prophylaxis
PF3 form	Police Form 3
PMoRALG	Prime Minister's Office, Regional Administration and Local Government
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SOSPA	Sexual Offenses Special Provisions Act
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Diseases
SV	Sexual Violence
TDHS	Tanzania Demographic and Health Survey
UN	United Nations
UNFPA	United National
UNICEF	United Nations Children Education Fund
UNODC	United Nations Office of Drugs and Crime
USAID	United States Agency for International Development
VAC	Violence against Children
VAW	Violence against Women
WAMATA	Walio katika Mapambano ya UKIMWI Tanzania
WHO	World Health Organization

ABSTRACT

This was an exploratory study of experiences of women survivors of sexual and gender-based violence in seeking medical care in Kibaha District. In this study, a close assessment of lived experiences and challenges in accessing medical care were the main focus. Purposive and snow-ball sampling were used to select 41 informants for in-depth interviews. The informants were from three administrative wards: Mlandizi, Magindu and Kwala wards. Six key informants were purposively drawn to give insight on how the medical management of SGBV survivors is done in the existing support structures as well as the perceived challenges that hinder women from accessing quality medical care. Further, two women were purposively selected to give case narratives based on their lived accounts after experiencing sexual violence and seeking medical care in the existing medical structures. Finally, three focus group discussions with community members as well as representatives of village and ward multi-sectoral committees on violence against children were held to gather community perceptions on SGBV and challenges women survivors encounter while seeking medical care in the district.

The results reveal that sexual violence is perceived as “completed” sexual intercourse that involves force by a stranger or someone known or relate to the victim without consent such as rape and defilement; however “attempted sexual acts” are not regarded as sexual violence in the community.

This study also indicates that sexual violence is prevalent in KDC however, few cases are documented in formal structures including health facilities; majority of adult women do not report sexual abuse particularly perpetrated by intimate partners. Culture plays significant role in perpetuating gender inequalities and fueling sexual and all forms of violence against women and children in Kibaha. These socio-cultural practices contribute both to women’s vulnerability and to their lack of autonomy and agency to respond to threats of violence.

The study observed that various factors act as barriers to access to quality medical care among women survivors of SGBV including; limited understanding on where, how and when to seek help, lack of confidence, long distance to support systems i.e. health facilities and police stations; lack of confidentiality among service providers, Discriminative cultural Norms and social stigma and women's illiteracy on their basic health rights. Economic dependency and poverty are among the factors that prevent them from seeking medical care, as they would love to due to the high costs of services.

Basing on the above findings, this study recommends for the improvement of healthcare response to SGBV in Kibaha district particularly by ensuring the availability of skilled medical personnel and adequate supplies for caring of survivors of SGBV in both selected health facilities that offer the services and creation of a One Stop Center (OSC). The initiation of multi-sectoral response to sexual and gender-based violence especially those that aim to improve the lives of women and children as well as effective community awareness programs on gender and sexual violence is of paramount importance. Also, there is need for the implementation of the relevant laws and available support services to survivors of sexual and gender based violence.

1.0 CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Sexual and Gender Based Violence (SGBV), has been recently recognized as a major public health problem and basic human rights violation and a development concern throughout the world. The term SGBV is sometimes used interchangeably with “violence against Women” (VAW) to mean any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or in private life (WHO, 2013). These acts occur on massive scale and takes various forms throughout women’s and children’s lives, ranging from Child Sexual Abuse (CSA), early marriage, female genital cut, rape and sexual assaults, forced prostitution, and domestic abuse, to the abuse of elderly women (Krantz and Garcia-Moreno, 2005). The United Nations recognize that violence is overwhelmingly directed towards women and girls as the subordinate gender characterized by power imbalances and men’s desire to control women’s sexuality and other inequalities.

Violence against women is not confined to a specific culture, region or country, or to particular groups of women within a society. The World Health Organization (WHO) estimates that, about 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives. However, some national studies show that up to 70 per cent of women have experienced physical

and/or sexual violence from an intimate partner in their lifetime (WHO, 2013; Amaya et al., 2016). In Kenya, almost half (45 percent) of women aged 15-49 years have experienced either physical or sexual violence (KNBS and ICF Macro, 2010). Tanzania is no exception; violence against women is widespread; at least 20% of Tanzanian women aged 15-49 years and about 14% of women in Kibaha district have experienced sexual violence in their lifetime respectively whereas 44% of ever-married women had been physically and/or sexually abused by an intimate partner (NBS, 2010; McCleary-Sills et al., 2012). Furthermore, both boys and girls may be exposed to sexual violence in childhood as data revealed that slightly more than 1 in 10 girls worldwide have experienced forced intercourse or other forced sexual acts at some point in their lives; and the most common perpetrators are current or former husbands, partners or boyfriends, a relative or authority figure (UNICEF, 2014).

In Tanzania, nearly 75% of children under the age of eighteen as compared to 66% of girls in Kenya had experienced physical violence and about one third of adolescent girls (28%) and 13% of boys report forced sexual initiation in each year (NBS, 2011). Also, trafficking of women and girls for forced labor and sex is widespread as about 70 per cent of girls and women together are trafficked every year and girls represent two out of every three child trafficking victims (United Nations Office of Drugs and Crime (UNODC), 2014). Violence Against Women (VAW), sexual violence in particular has severe impact on physical and mental health of a victim. Apart from causing physical injury, it is associated

with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences (WHO, 2013).

The increasing prevalence of sexual violence in Tanzania and the multifaceted consequences of sexual violence on women have led to the initiation of multi-level and multi-sectoral responses that coordinate key preventive services a survivor may require (e.g., comprehensive health and psychosocial services and justice system to prosecute sexual offenders) complimented by efforts to eliminate the tolerance of violence and increased investment in prevention interventions as it is stressed by World Health Organization.

The national GBV response includes development of policy frameworks and legislations that mitigate against its occurrence as well as protecting the vulnerable groups including women, children and punish perpetrators and the initiation of various institutional reforms within government ministries to ensure gender mainstreaming. This includes the provision of high-quality and comprehensive medical services and procedures to survivors that address the physical and mental health consequences of their experiences and aid their recovery from what is a traumatic event; including psychological support; treatment for possible sexually transmitted diseases (STDs), prophylaxis against HIV, treatment for physical injury as well as, examinations and documentation of injuries for legal purposes. Moreover, the appointment of gender focal persons to coordinate the gender activities and to formulate programs and budgets related

to SGBV plays an important role in the fight against SGBV (Tanzania Ministry of Community Development, Gender and Children, 2012).

Despite the supportive policy environment for preventing and responding to SGBV, the problem is still escalating in alarming rates and remains the least talked about violation of mainly women's human rights. Researches in this field have a general agreement that sexual abuse is the most underreported and in reported instances, retracted and settled phenomenon (Human Development Trust (HDT), 2011). It is a truth that is hidden in high secrecy; it shocks and traumatizes both the victim and the immediate caregivers when discovered. In spite of its critical role in responding to violence, the health sector faces severe constraints in services delivery and on the capacity to provide comprehensive survivor-centered care; as researches suggest that in most countries, particularly low and middle income countries, health services have been neglected; is of poor quality, insufficiently resourced and not easily accessible to survivors; and when available, they do not meet the needs of survivors; and very few have been properly evaluated (Betron, 2008).

The big question therefore remains as to why the Tanzanian health system fails to provide adequate medical services to survivors as well as protecting women from sexual abuse. The long-standing failure to protect and promote the rights and freedoms in the case of violence against women is the main concern of the Declaration of the Elimination of Violence against Women (1993) as it was of this project. This study therefore, explored more on survivor's subjective

experiences in accessing medical services in existing support structures in Kibaha District Community (KDC) as well as the systems and norms that promote and perpetuate violence against women (VAW) in coastal community that may inhibit them from seeking help after experiencing violence. The aim of the study was to document the lived experiences of SGBV survivors in order to generate evidence on the factors that act as barriers to access to medical services by women survivors of SGBV.

1.2 Problem Statement

Sexual violence is one among the rampant forms of SGBV in Tanzania as in many parts of the world. Although there is a growing awareness of SGBV and increased efforts at a policy level to address the problem in many parts of the world (McCleary-Sills et al., 2012, sexual abuse including rape often goes unnoticed, undocumented and under reported.

A number of initiatives have attempted to assess the scale of the sexual and gender based violence at the international, regional and national levels using two data sources including population-based self-reported victimization surveys and police and/or health facility-reported administrative surveys. However, researches suggest that the number of women who disclose victimization in formal sources including medical personnel is only a fraction of those attacked hence grossly underestimate the prevalence of sexual abuse in the community (Devries et al., 2006; Garcia-Moreno et al., 2006; Gelaye, 2010).

According to the United Nations Economic and Social Affairs, in the majority of countries with available data, less than 40 per cent of the women who experience violence seek help of any sort; and most look to family and friends and less than 10 per cent of women look to formal institutions and mechanisms, including police and health facilities (United Nations Economic and Social Affairs, 2015). Further, the WHO Multi-country Study on Women's Health and Domestic Violence against Women shows that more than 60 percent of Tanzanian SGBV survivors had never gone for help to any formal service or report the violence to any formal or law enforcement authorities) and only those whom were not able to endure more violence (59%) or badly injured (25%) sought help (WHO, 2005; UN women, 2013). This is consistent with the Tanzania Demographic and Health surveys which show that, while nearly half of survivors of physical or sexual violence sought help to stop the violence, only few of them seldom seek help from the police, lawyers, or medical personnel (6%, 1%, and 1% respectively) (TDHS, 2010; McCleary-Sills et al., 2012).

Furthermore, the National VAC Survey Report shows that approximately, about 7% of girls and about 3% of boys were physically forced or coerced into sexual intercourse before the age of 18; but only 1 out 5 girls and 1 out of 10 boys seek support from formal systems after experiencing the abuse; and of those, only 1 in 10 girls and 1 in 25 boys whom were sexually abused received services; and about 16% of both girls and boys would like additional services such as counseling, police or social welfare support (NBS, 2011). Moreover, a study by NOLA-a local NGO revealed that over 50% of the children interviewed in

Kibaha district have acknowledged being abused. However, most of them do not report sexual abuse and the same applied to parents/guardians and communities at large. This suggests the complexities of rape, disclosure, reporting and documentation (NOLA, 2012).

Previously, community perceptions of sexual violence, disclosure of events and support to women survivors have been investigated in urban Tanzanian settings (Laisser et al., 2009; Kisanga et al., 2010; Muganyizi et al., 2011; McCleary-Sills et al., 2012). Various factors that prevent women from reporting and utilizing the existing formal support mechanisms includes among others variations in awareness of services and their availability and socio-cultural barriers (United States Agency for International Development (USAID), 2008; Laisser et al., 2009; Kisanga et al., 2010; Muganyizi et al., 2011). However, there is a gap in knowledge on the reasons as to why women survivors of SGBV do not seek medical care. Equally scarce is research on the challenges that hinder women survivors' access to appropriate medical care in rural settings, particularly in Kibaha district council.

Therefore, this study, aimed at exploring more on survivor's lived experiences in seeking medical care (both negative and positive) as well as the challenges women survivors of SGBV face in the process of seeking medical care thus preventing them from accessing appropriate medical services with a focus on Kibaha district.

The study was guided by the following research questions:

- i. What are the experiences of women survivors of SGBV in seeking medical services from the existing medical system in Kibaha district?
- ii. What challenges do the women survivors of SGBV face in seeking medical care in Kibaha district?

1.3 Objectives of the Study**1.3.1 General Objective**

To explore the experiences and challenges faced by survivors of SGBV in seeking medical care in Kibaha district.

1.3.2 Specific Objectives

- i. To document the lived experiences of women survivors of SGBV in seeking medical care in Kibaha District.
- ii. To investigate the challenges faced by the women survivors of SGBV in seeking medical care in Kibaha District.

1.4 Assumptions of the Study

- i. Women Survivors of SGBV have traumatic experiences in the process of seeking medical care in Kibaha District.
- ii. Women survivors of SGBV face different challenges in accessing medical care.

1.5 Significance of the Study

Violence has been recognized as a health problem and protection against violence as a human right issue. Overall, violence, whether self-inflicted, interpersonal or collective, is among the leading causes of death among people aged 15 to 44 years (Krug et al., 2002). Violence against women has been identified as an obstacle to the achievement of equality, development, and peace (Fourth World Conference on Women, 1995); limits women's contribution to social and economic development (Elson, Lynne and Keesbury, 2010), thereby contributing to hindrance in the achievement of the Sustainable Development Goals (SDGs) (5) to end all forms of discrimination against all women and girls everywhere by eliminating all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation and other national and international development goals.

The social service sector in Tanzania, health sector in particular bears much of the economic burden of sexual violence through public financing or direct public expenditures (Tanzania Health Sector Strategic Plan III (HSSP III) 2009–2015). The government has put in place various strategies to respond to the problem, but preventing sexual violence and its heavy consequences remain a big challenge in Tanzania as it is for most countries. Hence the need to undertake further research so as to expose the hidden problems in health service delivery as well as the community needs and barriers to care in rural settings and suggest strategies to end sexual and gender-based violence and stipulate how the survivors can be well supported.

Since over two-thirds of Tanzanians inhabit the rural areas and rely on public local health facilities to provide them with basic health services (Kwesigabo et al., 2012), an understanding of this system with its inherent weaknesses has the potential of recommending proper ways of improving rural health care systems. The improvement of the health care delivery will not only attract more rape victims to seek healthcare but encourage them to understand that options exist for them.

Findings from the study will therefore, provide useful contribution especially in unmasking the gaps in the available medical services and the plight of women who have experienced sexual violence. Data will provide the necessary evidence for an informed policy interventions and reforms in safeguarding the plight of the victims. It will also provide the necessary evidence for advocacy by like-minded institutions and individuals who fight for the rights of women and children in Tanzania. .

1.6 Scope and Limitations of the Study

This study was conducted among women who in some point of their lifetime had experienced sexual and gender based violence in Kibaha District Council which is one among seven districts in coast region, Tanzania. It mainly focused on the experiences and challenges faced by women survivors of SGBV in seeking medical care in the study site of KDC. Improving the situation of sexually abused women in seeking medical care is largely possible when their realities are captured in the immediate settings that reflect their beliefs, values and

medical care seeking patterns. Given the qualitative nature of this study as well as the sensitivity of the research topic, only a small number of 42 subjects were reached, and the legal barriers were beyond the scope of this study.

Moreover, Cultural norms around gender-based violence (which is a literally new topic of debate for Tanzanians) coupled with shame and culture of silence specifically on sexual abuses made data collection on this sensitive topic particularly challenging. It is still perceived as a taboo for some women from the Coast region to discuss issues to do with sexual act whether being forcefully or not with strangers and people whom they do not relate with. Language was also a barrier particularly among Maasai women, as in most of the terminologies used were new to them. To avoid this discomfort, as well as fear of sharing their experiences and revealing the challenges in accessing health services, clear definition of various terms used were given prior to the interviews so as to throw light on the people's frame of mind and behaviors towards outsiders. In addition to that, efficient communication and rapport with respondents was maintained during the entire study as well as for ensuring the validity of data on sexual violence.

To ensure complete privacy and confidentiality, respondents were asked to choose secure environment for the interview since asking about or reporting violence, especially in households where the perpetrator may be present at the time of interview carries with it the risk of further violence. Also informed consent of respondent was obtained for the study to start.

1.7 Definition of Key Terms

Access to medical care: It refers to the timely use of SGBV services to achieve the best health outcomes

Consent: Making an informed choice freely and voluntarily to do something without the use of threats or force.

Perpetrator: someone who commits sexual violence

Sexual violence: it refers to attempted or completed sexual acts with a woman without her consent, which include inappropriate and/or unwanted touching by force or under unequal or coercive conditions..

Survivor: A female who has been sexually abused. This term will be used interchangeably with victim.

2.0 CHAPTER TWO: LITERATURE REVIEW

This section covers the review of literature on the overview of SGBV, medical responses and challenges faced by women in accessing medical attention and legal redress. The review is done along the lines of the specific objectives. The review also presents the theoretical framework adopted in the study.

2.1 Conceptualizing SGBV

SGBV has been recognized as a human right violation and a major health and development issue that affect women of all ages (WHO, 2013). Broadly, SGBV includes all forms of physical, economic, psychological, and sexual violence (SV) that are related to the survivor's gender in a society or culture (USAID, 2006). While data on sexual and gender-based violence are very limited, it is estimated that globally, 35% and 7% of women experience physical and sexual violence from an intimate partner and by someone other than an intimate partner respectively at some point in their life time.

The available data shows that, in Africa, approximately half of the women aged between 15 and 49 (48%) in Zambia and 39% of women in Kenya have experienced physical violence, and one in five (21%) in both countries reported sexual violence (Keesbury et al., 2012). The roots of violence against women originated from the long term discrimination against women which resulted from not only biased cultural practices and societal attitudes but also gendered policies and laws that failed to address gender equality issues or have some

discriminative provisions (Human Development Trust (HDT), 2011). Violence itself and a threat to violence are the ultimate weapons used by most men to affirm their masculinity or to ensure continuing control and male domination on women (Bunch and Carrillo, 1991).

Having a sexual partner is a risk for sexual abuse as researches suggested that victims of sexual and gender-based violence are abused inside what should be the safest environment; either by someone dear and well known to them, or those with responsibility for protecting them in difficult situations (Muganyizi, 2012). WHO Reports show that in some countries, nearly 1 in 4 women is sexually abused by her partner which is also the reality in Tanzania. Besides, women are sometimes sexually abused in public spaces in their lifetime as it is reported by 92 per cent of women who participated in a study conducted in New Delhi in 2012, while others (88%) are verbally harassed (i.e. unwelcome comments of a sexual nature, whistling, leering or making obscene gestures) in some point in their lifetime (UN Women, 2013).

2.1.1 Consequences of Sexual and Gender-based Violence

Violence against women is associated with potential deleterious health and social consequences. Various researches into the causes and consequences of the violence have documented the health burdens, intergenerational effects and demographic consequences of such violence (UN general Assembly, 1991; Heise et al., 1998; Jejeebhoy, 1980; UN Women, 2013). SGBV can negatively impact physical, reproductive, and psychosocial well-being.

Violence increases a risk for HIV and STI acquisition and consequence of being HIV infected, and other negative health and psychological outcomes are well known (Krug et al., 2000). Men who adhere to inequitable gender norms are more likely to perpetrate violence against their partners, engage in unsafe sex with multiple partners, and abuse alcohol and drugs, which increases the chances of getting HIV and other negative health outcomes to them and their partners (McCleary-Sills et al., 2012; UN, 2013).

Sexually abused women are at higher risk of getting STI as surveys conducted in rural Tanzania and urban South Africa suggested, although the association of rape and these infections is subject to other factors (Adams· Girardin and Faugno, 2000). According to WHO, women who have been physically or sexually abused by their partners are more than twice as likely to have an abortion or to give birth to a low-birth weight baby, almost as twice as likely to experience depression, and in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced intimate partner violence (World Health Organization, 2013). In Tanzania, a study shows that HIV infected women were two and half times more likely to have experienced violence by their partners than non-infected counterparts (Maman et al., 2002: UN, 2013).

Acts of sex abuse violates the victim's physical integrity and psychological makeup, which is why sex abuse is identified as one of the most dehumanizing offenses. SGBV abuse is associated with psychological problems such as post-traumatic stress disorder, anxiety, depression and low self esteem that can lead

to victimization; as well as reduced ability of a woman to work, care for her family and contribute to society and her life in general (UNFPA, 2008).

Nevertheless, violence of any kind has a grave direct and indirect impact on the economy of the country. Direct costs include the cost that survivor incurs in the process of seeking support services from existing systems including transportation, medical fees, legal costs. Indirect are the costs related to reduced employment and productivity and the humiliation experienced after violence (UN, 2013). SGBV have profound consequences not only to a woman's health and well-being but also have repercussions to families and communities across generations, and reproduces other violence in society (Williams et al., 2008).

2.2 Sexual and Gender Based Violence in the Tanzanian context

In Tanzania, SGBV is widespread as it is in many sub-Saharan countries, It is a grave reality in the lives of most Tanzanian women. The Tanzania Demographic and Health Survey (2010) shows that over 20% of women aged 15-49 years and nearly 40% reported having experienced sexual and physical violence in their lifetime respectively; and 29% of adolescents report having forced first sexual intercourse (mainly by adults) before reaching adulthood (NBS, 2011). Furthermore, Tanzania is among the countries with the highest prevalence of non-partners sexual violence after the age of 15 years (Bott, Morrison, & Ellsberg, 2005). This is also the case in Kenya as has been reported by the key informants who participated in the study on Factors associated with sexual

violence among female patients aged 14-24 years at Kenyatta National Hospital (Carmen, 2010).

2.2.1 Socio-cultural norms related to women's sexuality

Like most African countries, there are lots of customary norms which subordinate women and privilege men in Tanzania. Male superiority is emphasized within and amongst all social structures (family, community, social and economic structures). Most communities practice patriarchal kinship pattern whereas husband's clan are entitled to the inheritance and decision making power and women have no voice in any decision concerning sexual matters (when, how and when to have sex) even in regards to their own health (Swantz,1996; Mbunda, 1991). The patriarchal norms discriminate women and girls in education, earnings and health; oppressive in mutual and social relationships, and are exploitative in economic realm. The literacy rate is estimated to be 73%, but it's higher among men (82%) than women (72%); whereas in Kibaha district, Literacy rate is 79% of which 73% are women and 85% are men. Overall, 19% of Tanzanian women in reproductive age (15-49 years) have received no formal education, almost twice the proportion of men (10%) (NBS, 2011).

To date, in most rural areas, girl's education is not valued and regarded as waste of resources and delay in economic prosperity. Unfortunately, this attitude is also prevalent amongst women, as it common for majority of women to educate their

sons who they believe would look after them during old age and leave girls who would get married and start their families elsewhere.

Furthermore, there are some socio-cultural practices that perpetuate gender inequalities and contribute both to women's vulnerability and to their lack of autonomy and agency to respond to threats of violence. Some of these practices include initiation rites through a special kind of training for girls and boys. . The Zaramo-the ethnic group along the coast of India Ocean in Tanzania for instance, practices popular "Mwali" tradition where by a menarche girl (11-20 years) is concealed and trained on the future responsibilities as wife and mother; which has been long associated with preparing them to become submissive to men (Muganyizi et al., 2011). As regards to sexual matters, a woman is supposed to submit to sex with her husband in any condition, and a husband cannot be guilty of rape upon his wife since she has consented to that matrimonial contract (Swantz, 1966). This is evident in a WHO multi-country study in this area, as 90% of respondents reported wife-controlling behavior, which is the highest among 10 countries that participated (Garcia-Moreno et al., 2006).

Living in poverty makes women particularly vulnerable to male violence against them; and puts women and young girls at risk of early sexual debut, transactional sex and unwanted pregnancies (Rogan et al., 2010). Majority of young girls and women in Northern Tanzania engage in transactional sex so as to obtain luxurious commodities and consider it normal sexual relationship (Wamoyi et al., 2010).

Societal acceptance of SGBV is common in Tanzania. SGBV policies and services in Tanzania show that, in many communities, various forms of SGBV are seen as normal and accepted by both men and women; these includes intimate partner violence, physical and sexual violence (McCleary-Sills et al., 2012). Similarly, the 2010 TDHS found that majority of women (53.5%) and a third of men (38.1%) concur with at least one justification of wife beating (NBS, 2011). The oppressive customary norms have a profound impact on woman's voice, agency, and participation, endowments and opportunities which are key dimensions for gender equality and women empowerment alongside freedom from the risk of violence in ensuring they have the ability to make meaningful choices in their lives and can act on those choices (World Bank, 2012).

2.2.2 Policy Frameworks for SGBV in Tanzania

The government of Tanzania has made strides in the promotion of gender equality and human rights as it has been recommended by various international and national instruments including UN Convention on the Elimination of All forms of Discrimination against Women (CEDAW) of 1985 and the Beijing Platform for Action. At regional level, Tanzania has ratified various instruments including African Union Charter and its Protocol on Human and Peoples' Rights; Charter on the Rights of Women in Africa (2003); Southern African Development Community (SADC) Gender Declaration (1997) and its Addendum on the Prevention of Violence against Women and Children of Southern Africa (1998); and SADC Protocol on Gender and Development (2008). At national level, gender equality principle has been enshrined in the

Constitution (1977) and along that, the government has initiated various legal, policy and institutional frameworks that are conducive for enhancing women's legal capacity, economic empowerment and poverty reduction, women's political empowerment and decision making and women's access to education and employment. The key gender-related components of the policy frameworks include the Tanzanian Development Vision 2025; National Strategy for Growth and Reduction of poverty 2010-2015 (MKUKUTA II, 2010-2015); National Women and Gender Policy 2002, and the associated National Strategy for Gender and Development (NSGD) 2005. MKUKUTA II identifies among its goals sexual abuse and domestic violence: "improved personal and material security, reduced crime, and elimination of sexual abuse and domestic violence" (Tanzania Ministry of Community Development, Gender and Children (MCDGC), 2012).

Moreover, government through Ministry of Health and Social Welfare (MoHSW), has taken further milestone by passing two policies on SGBV which are the National Policy Guidelines for Health Sector Prevention of and Response to Gender-based Violence, that outlines the roles and responsibilities of the MoHSW and other stakeholders in the planning and execution of comprehensive SGBV services as well as the National Management Guidelines for the Health Sector Response to and Prevention of Gender-based Violence that provides a framework to guide comprehensive management of GBV survivors; encompassing medical management and aims to strengthen referral for psychosocial care and support services, with linkages to social and legal

protection structures and with community. On top of that, a national clinical training curriculum has also been developed for HCWs and Social welfare officers, which include SGBV screening protocols.

While the MoHSW has taken the lead on these initiatives, the Ministry of Community Development, Gender and Children (MCDGC) have also established a national multi-sectoral committee on violence against women and children, and developing a community sensitization strategy so as to address SGBV in the country. To compliment government efforts for eliminating violence against women, various non-governmental organizations (NGOs) were established (MoHSW, 2011). The efforts, though laudable, have yet to yield significant gains and foster the envisioned culture of respect for the rights of men and women, boys and girls.

Violence against Women (VAW), particularly rape still persists in Tanzania. Although the SOSPA (1998), stipulates stiff sentences of up to 30 years imprisonment for perpetrators of rape, acts of sexual violence continued to persist due to accepted social and cultural norms, attitudes and perceptions which undermine women and girls' rights to own and inherit family property and engage in formal and informal sector. According to the Ministry of Home Affairs, the annual SGBV incidents reportedly increased from less than 10,000 between 1990 and 2007 to 23,012 cases in 2015. The leading types of gender based violence cases reported were rape (5,802), assaults causing bodily harm (4,092) assault (3,674), abusive language (2,892) and grievous bodily harm

(2,798) (Tanzania Police Force & NBS, 2015). However, the actual number of SGBV cases might be higher as most cases go unreported. Moreover, inequalities still persist between rural and urban areas in regards to capacity, as they do for the access to education, physical assets including land, and political and economic opportunities for girls and women as a result of gender biased-policies and laws that are also poorly enforced to offer fully protection to women and girls (HDT, 2011).

2.2.3 Health sector's Responses to Sexual and Gender-based Violence

Sexual Violence has serious health consequences on survivors, thus provision of quality care and support is important for the improvement of their survival and wellbeing. The MoHSW has decentralized public health system and infrastructures to easy accessibility of services to survivors and community at large. The infrastructure includes delivery of health promotion, disease prevention, curative, rehabilitation, and social welfare services in public health facilities. The district and municipal authorities are responsible and accountable in the provision of healthcare services to the population in their area of jurisdiction including SGBV prevention and response activities.

The clinical management of SGBV is done at all health facilities through the established national referral system where survivors are provided with comprehensive care from dispensaries to health centers and hospitals at district, regional, and national levels depending on the on the level, capacity and the available resources (Ministry of Health and Social Welfare (MoHSW), 2011);

although services may vary depending on the level, capacity and resources available. The Services include post-exposure prophylaxis (PEP), Emergency Contraceptives (EC), HIV and STI screening; counseling as well as collection of forensic evidence and documenting all the findings. Since Survivors who report sexual violence are required to obtain a PF3 form during or after they receive medical care, medical personnel must complete the PF3 and refer survivor to the police; as well as representing survivor in court as a factual witness.

At the primary level, health dispensaries and health centers provide the most basic care and assist survivor with the first aid for minor injuries, and refer the complicated cases to a next-level facility that offer more comprehensive care to survivors; whereas district hospitals provide both inpatient and outpatient and some laboratory services. Health care providers at all levels are also responsible for educating and linking survivors to other SGBV services. However, the comprehensive services for SGBV survivors are available only at regional hospitals, referral hospitals, District Designated Hospitals (DDH) as well as selected health centers (MoHSW, 2011).

Comprehensive Medical care for SGBV survivors as done through two widely accepted modalities within a multi-sectoral model include: the “integrated services model” where clinical services for SGBV survivors are integrated into existing health services and one stop center model (Keesbury et al., 2012; CARE, 2013).

Through the first model, GBV services are integrated into all healthcare points of entry whereby at a minimum, survivors are screened, given information on how SGBV impacts their health, and provided with services and support according to the facility level; and then connected through referrals to appropriate police, psychosocial, shelter, and legal aid support and other existing community support structures. Through the later, clinical services are co-located with police, legal, and psychosocial support services within a stand-alone center at Tumbi hospital. This is the facility-based OSC- managed by Tumbi regional referral hospital (that is owned by shirika la elimu Kibaha). It was established in 2016 with support from Plan International and UNICEF who renovated the OSC building and donated office furniture and equipment i.e. fax machines, photocopiers etc. The OSC is situated in a standalone building in Tumbi hospital, and is staffed with Police Officers, medical officers and Social welfare Officers. All OSC functions have been integrated into hospital's routine activities that are budgeted for in a Comprehensive Hospital Operational plan.

The center receives clients from coastal region and some as far as from Dar es Salaam for additional and specialized services. Survivors receive police services, trauma counseling and continued psychosocial support at the OSC and are referred to different departments within the facility for fast track free clinical care. They are also linked to other partners for legal, social support and police involvement.

Despite the widespread use of one-stop center model for addressing GBV- sexual violence in particular- across the world, they are becoming popular in various

countries in Southern and Eastern Africa led by Kenya and South Africa (Keesbury, and Askew, 2010; CARE, 2013).

2.3 The experience of SGBV Survivors in seeking medical care and support

Due to the complexity nature and long-lasting consequences of Sexual violence, care for victims is of high priority. Studies show that of recent, the SGBV comprehensive services for SGBV survivors including medical care, Gender and Children's Desks in police stations and several promising civil society interventions are increasingly available in Tanzania especially in urban areas (McCleary-Sills et al., 2012). Despite Governments and non-governmental organizations efforts to increase the availability of services to the community, access to and utilization of services has been a problem particularly in rural areas. Women have been experiencing different and traumatic episodes in seeking for medical care from the existing health care systems. Studies on the same show that poor women and girls are least likely to have access to adequate and appropriate care due various factors including the low socio-economic status and social stigma cast on women who experience SGBV that reduce their morale to demand for services ((Oxaal, Z and Baden, S, 1998)

2.3.1 Gender inequality and women's economic dependency

In most patriarchal societies, women are normally less powerful than men. The intra-household resource allocation and decision-making in the demand for the legal and health care services as well as socio-cultural constraints limit their

access to health care.. Low self-esteem associated to a low status reduces woman's agency and determines her options to resist violence and in the same way lead to women desert their own health needs. Being poorly educated, some women might not understand that the problems they are suffering from as consequences of violence can be successfully treated (Overstreet & Quinn, 2013).

Gender discrimination in ownership of property and limited access to socio-economic opportunities reduce women productivity and increase economic dependency on men. Studies suggest that, the cultural value of being a "proper wife" or a "good mother" and "loyal" to the family may lead women to not reporting SGBV to police since they are economically dependent on their husbands. Furthermore, women living in poverty tend to have limited access to formal institutions that might offer support and protection against violence including health, legal, psychosocial and police services partly due to cost associated with such action including financial and sometimes the costs of facing social stigma and rejection for having made the violence public (Pickup et al., 2001; Siwal B.R (n.d))

2.3.2 Limited knowledge on women's health rights and the existing SGBV services

In their study, Overstreet & Quinn, (2013) noted that, in order to demand for services, women survivors of SGBV must understand that abusive situation is unbearable and decide to report and seek help from the existing support system

of their choice. However, the majority of women have limited understanding of what constitutes sexual abuse and lack awareness that living free of violence is their fundamental right as well as where to go for services and the procedures involved particularly in the rural settings (Muganyizi, 2010). On top of that, a lack of education about 72-hour window period for reporting of sexual abuse cases may reduce the chances that survivors seek immediate care (Harris L and Freccero J., 2011). Survivors must be able to negotiate and interpret not only the abuse itself but community response to the disclosure of the abuse. Without this knowledge, the survivors are not likely to seek for support and services (Harris L and Freccero J., 2011; Overstreet & Quinn, 2013).

2.3.3 Limited access to a health care location where SGBV services are available

Due to their triple roles in society, Oxaal, Z and Baden, S. suggest that women are mainly the principal providers of household health care, thus the demands on their time greatly influences household health care seeking behavior. Heavy work loads among poor women and the opportunity costs of time in seeking care may hinder their access to care. The actual and perceived delays in getting services have implications to health seeking among survivors and at the same reflect significant barriers to care as the long waiting time not only reduces patients satisfaction but also increases the number of patients who leave before getting treatment particularly women (Overstreet & Quinn, 2013).

Furthermore, the economic dependence of women from low income areas, coupled with little free-healthcare service providing centers in the immediate environment, also acts as a deterrent to seeking health care (Jackson, 1996). Transport costs and time to travel to health facilities, as well as long waiting times at poorly staffed health facilities, all deter women from seeking care (Oxaal, Z and Baden, S, 1998).

2.3.4 Community Acceptance of SGBV, social stigma and women's access to services

Women in patriarchal society are expected to be submissive in giving sex, and thus the abuse of women is seen as “normal behavior” and “private matter” and rape is not to be considered as violence (Heise, 1998; Jackson, 1996). In the same way, sex is considered a man's individual right, thus there's nothing like “mutual consent” and since sex is a taboo topic of discussion to women, it becomes difficult for them to neither report the violence to medical personnels or police nor seeking public accountability in a court of law (Harris L and Freccero J., 2011).

Moreover, attitudes and beliefs about sex determine how communities respond to incidences of sexual violence. The conception of male and/or female and perceived gender roles shape individual and community perceptions and definition of violence, and which forms of violence are highly prioritized and their response towards disclosure of violence. (Harris L and Freccero J., 2011; Heise, 1998).

Furthermore, in some instances a woman may be blamed of sexual violence, rape in particular since she has power to seduce the perpetrator into illegal act, thus the typical community response tends to overlook the woman's individual harm and seek to redress, instead to blame, isolate and stigmatize her for the dishonor and shame brought to the family (Harris L and Freccero J., 2011).. The prevailing harassment and abuse of women in patriarchal societies is highly contributed by the exploitative customs and traditional practices that expect women to be submissive to their husbands (HDT, 2011).

The social stigma attached to SGBV has negative impact not only to individual woman, but also families and community at large. On an individual level, the sense of humiliation and negative beliefs about SGBV disturbs survivor psychologically and the anticipation of how will society respond once they know about the abuse impact the survivors decisions to disclose and seek help from the existing support systems including family and friends. Furthermore, the societal cultural ideologies that stigmatize victims of SGBV and stereotyped beliefs and attitudes that victim provoke their own victimization hinder help-seeking. In the same way, cultural stigma may affect the attitudes and behaviors of families and people who provide support to survivors of SGBV.(Overstreet & Quinn, 2013).

Due to the intensive social stigma towards survivors of sexual violence; or fear of being blamed or rejected by their families for disclosing the abuse, or being subjected to further violence, women may decide not to report the abuse (Mugweni et al., 2012). Campbel et al. (2001) noted that disclosing sexual violence is a must in receipt of appropriate care and support, and the fact that violence is traumatic event, disclosure is associated with better health outcomes.

2.4 Challenges faced by the women survivors of SGBV in seeking medical care

As it is stressed by WHO, survivors of any form of violence require comprehensive and gender sensitive health-care services that tackle the physical and mental health consequences and assist them to recover from a traumatic experience (WHO, 2013). Health facilities are the first institutions that a survivor comes into contact with, therefore they should be able to connect survivors to other community-based support systems including police, shelter and legal aid. However, the availability of post-rape services as well as the attitudes and approaches by health care providers have the implications on survivor's physical and psychological health and safety (Harris L and Freccero J, 2011).

The differences in access to health services that to large extent affect women and other vulnerable groups in society; as inaccessibility of services reduce the ability of women to realize their potentials and negatively affecting quality of their life. Various studies have documented the structural barriers in the health care system that impact services delivery and the capacity to provide SGBV

comprehensive people-centered care survivors' and hence lead to unmet health needs as the result of SGBV, delays in receiving appropriate care and utilization of quality care (Adams et al., 2000; McCleary-Sills et al., 2012; WHO, 2013).

2.4.1 Unavailability of medical care services

The major obstacle affecting survivors of SGBV is limited medical care services especially in rural areas in terms of physical availability of services, insufficient resources both human, material and financial resources and the impact of services to survivors (Health outcomes). When services are easily available and facilities have adequate supply of material and human resources, the possibilities to get optimal health care increase and as well those in need of services may have access to it (Overstreet & Quinn, 2013). However, the high costs of services and corruption have distasteful consequences. Moreover, poor quality of care and support as the result of unnecessary delays in service provision, absence of proper protocols; in appropriate response strategies for women survivors of violence; and inadequate training on SGBV among health care providers are among the hindrances to access to and utilization of services (McCleary-Sills et al., 2012).

2.4.1.1 Insufficient resources (financial, material and skilled manpower)

Provider capacity is one among the key barriers to quality and comprehensive care (Keesbury et al, 2012). Skilled primary care providers have an important role in increasing access to services to as they can create friendly environment

with SGBV survivors while offering integrated services in gender sensitive manner. The sustained patient-provider relationship and communication increase the opportunity for survivors to receive appropriate and timely services since they will have trust to providers and disclose their experiences (Manzi et al., 2012; WHO, 2013).

The shortage of trained medical personnel is another challenge that hinders health services delivery in Africa. This shortage generates long waiting time and full waiting areas in many public facilities, particularly in emergency departments (Keesbury and Askew, 2010). In their study, Manzi et al., (2012) reported the limited access of healthcare in Tanzania,. While most of hospitals are located in urban areas, the primary health facilities in urban areas lack human and material resources therefore, some crucial services are not offered in health centers and dispensaries. Tanzanian health sector is experiencing the critical shortage of skilled medical personnel (40%), that is contributed by poor incentives provided to the few available staff. Also, as it is shown in the HSSP IV, at present there are an inadequate number of trained social workers to meet the population needs (four social welfare officers in each Council and a social assistant at each ward) (MoHSW, 2011).

additionally, absence of effective staff supervision, poor transport and communication infrastructures and shortage of medicines and medical equipments are among the challenges facing health sector. McClearly-Sills, et al., (2015).

Nevertheless, the shortage of material resources and inconsistencies in post-discharge care of sexually abused females particularly in remote areas hinders survivors access to adequate care (Baelani and Dunser, 2011).

2.4.1.2 Negative attitudes of health care providers toward survivors of SGBV

In their study, Keesbury and Skew (2010) suggested that negative attitude towards women survivors of SGBV is one factor that impacted the quality of care. Being members of society, health care providers, police officers as well as staff from other GBV support systems may have the common misperceptions and stereotyped beliefs about SGBV acts and survivors, that not only reinforce stigma, shaming and blaming the victim but also consider the abuse as criminal justice issue and partner violence as domestic issue. This discourages women from seeking help and disclosing violence to health professionals and in turn opts for informal means or chose to not seek help at all.

2.4.1.3 Lack of Psycho-social services

As the first personnel to attend women who exposed to violence, healthcare providers must have appropriate skills and capacity to recognize signs of it and respond accordingly while prioritizing survivor's needs and safety and as well assist them to recover from the traumatic experiences (WHO, 2013). However, the available studies show that there is a huge gap in psychosocial services for survivors in all types and sources that provide SGBV support (McCleary-Sills et al., 2012). Also, many health facilities lack essential equipments and properly

trained staff to offer appropriate psychosocial-care and as the result, survivors often experience secondary trauma while seeking care in health care institutions. They may spend a lot of time while waiting for service and ending up being assisted by unskilled staff (Harris and Freccero, 2011). These situations discouraging survivors from seeking care and mean that providers cannot offer the expected quality care or they may not find trained personnel at the facility (Keesbury and Skew, 2010).

2.4.1.4 Lack of proper protocols and appropriate response mechanisms for survivors

Requirements that only doctors in public health facilities can collect forensic evidence undermine a survivor's access to justice and health care. However, the limited ability of medical systems to collect such evidence has been identified as a key barrier to quality care. Since survivors reports at lower level facilities first, they are in most cases referred to higher level facility where doctors are either overworked or not available at that particular time; and are also less likely than nurses to fully document cases, this can therefore create unnecessary delays in getting emergency medical services including PEP and EC. (Keesbury and Skew, 2010; Brown & Widney, 2001)

Additionally, in Tanzania like in many other countries, private health facilities, unlike the government-supported facilities are not mandated to complete PF3 forms that document evidence for use in legal proceedings. As a result, their capacity to respond to cases of sexual violence is very limited (McCleary-Sills

et al., 2012). This restricts accessibility of SGBV services in the country due to the fact that countrywide, about one-third of health services are provided by private facilities including Non-governmental organizations (NGOs), Faith-based Organizations (FBOs), and other private organizations that run health facilities basing on the mandate of each organization and specific center (McCleary-Sills et al., 2012; Abeid, 2015)

2.4.1.5 The high costs of services

Utilization of services depends on the affordability, physical accessibility and acceptability and not merely adequacy of supply. Women's economic dependency reduces their ability to pay for the high costs of services that is contributed to by direct and indirect costs, distance to formal providers (rural areas in particular) and this prevent them from utilizing the SGBV services (McCleary-Sills et al., 2012; Muranga, 2011).

2.4.2 Discriminatory Socio-cultural norms and stigma towards survivors

Community-level barriers that commonly undermine survivor's utilization of existing services are bound within cultures that disadvantage women over men. In most traditional societies, men are socialized as being superior to women in all spheres of life thus SGBV is considered normal (Betron, 2008). A study by Muganyizi (2010) shows that the persistent discrimination that is associated with some cultural practices and societal gendered attitudes that discriminate women and silence the survivors; the same way as the stigma associated with the abuse and consistent intimidation from the male perpetrators. Also a preference of

survivors and their families for resolving the issues at home through the male dominated local dispute resolution mechanisms - attributed either to deference or to traditional culture; fear of stigma if the abuse is known to the public ; and additionally, the family's choice to seek compensation directly from the perpetrators rather than through the established criminal justice system place further barriers to women's utilization of services (Keesbury et al., 2012). This is complimented by survivor's lack of opportunities to tell someone since in many settings, cultural taboos make open discussions on sexual matters difficult (Muranga, 2011; Ecker, 1994).

This literature review has established that sexual violence is still rampant in Tanzania and discriminatory cultural norms contribute to its persistence. The persistent discrimination is associated with some cultural practices and societal gendered attitudes while others are produced by ineffective policies and laws that have either failed to address gender equality issues or have gender discriminative provisions. The literature also shows that there are a number of constraints that women are facing in the process of seeking help if they decide to seek help from the existing channels in cases of violence. Some of which are related to capacity to deliver quality comprehensive services that include insufficient resources (human, material and skilled manpower); while others are related to women's ability to access services (user fees, distance, knowledge about their rights to quality health services). The existing gaps in health care systems affect not only the provision of appropriate support and care to survivors of violence but also survivor's help-seeking behavior. In this regard, lasting

progress cannot be made in improving the health and wellbeing of individuals and nations unless we change community perceptions and attitudes that trigger gender inequalities in society (McCleary-Sills et al., 2012; Brown & Widney, 2001; Keesbury et al., 2012).

2.5 Theoretical Framework

The theoretical frame that guided this study is the Phenomenology theory by Michael Jackson (1989). Phenomenological approaches are based on a paradigm of personal subjectivity and stress on the importance of individual perceptions and interpretation. The main goal of this approach is to develop an understanding of a phenomenon through the specific human experience, so as better understand a live experience and gaining insights into people's motivations and actions. The theory is designed to discover phenomena and bring to light issues which were previously overlooked or unnoticed (Lester, 1999).

SGBV is a complex phenomenon caused by various socio-cultural and economic issues coupled with poor visibility and outright impunity. It is the real translation of power, male physical strength and the long term cultural inequalities between men and women who, through stereotypical roles legitimize the violence and reduced consciousness against violence. Studying women's subjective experience is therefore, important in uncovering their descriptions of SGBV acts with the meaning associated with it; their experience through the process of disclosing and/or seeking medical care as well as implicit in the

intentional relationships that a woman as a victim lives with others in their daily life (Oliveira et al., 2015; Selic, Pesjak and Kersnik, 2011).

The experience lived as contained in the victim's life allows for an assessment of the existence of these women's dilemma, vitalizing in them the wish to seek services and/or get out of the situation. However, these desires are mitigated by the reactions and behaviors of others, and based on the perceptions of individuals, family, community and society at large, there is a visible effect on women's access to medical care.

2.5.1 Relevance of the theory to the study

Phenomenological methods are useful for highlighting the experiences and perceptions of individuals from their personal perspectives as well as for challenging existing structural and normative assumptions. This study sought to provide contributions to knowledge about sexual and gender based violence against women through exploring the experiences of women survivors of SGBV in accessing medical care and support. The phenomenology theory was used to get survivors experience and descriptions about the type of medical care they had received after sexual abuse, where and how they were treated; by whom; and their perceived challenges throughout the process of seeking health. Through understanding the experiences of women survivors of SGBV, it will be easy to reveal the magnitude of sexual violence among women in KDC as well as the understanding of the extent to which violence affect women, its multiple

consequences, and various factors that affect their help seeking behavior and of their lives and that of their families.

Adding an interpretive dimension to phenomenological research is believed to enable it to be used as the basis for practical theory, allowing it to inform, support or challenge policy and actions. Therefore, the application of this theory in this study has enabled the identification of issues that show inconsistencies and systems failures as well as to draw attention to various situations. Interpretation of the inferences also enables expansion of debates on the subject and improvement of medical care to these women, in a comprehensive and humane manner.

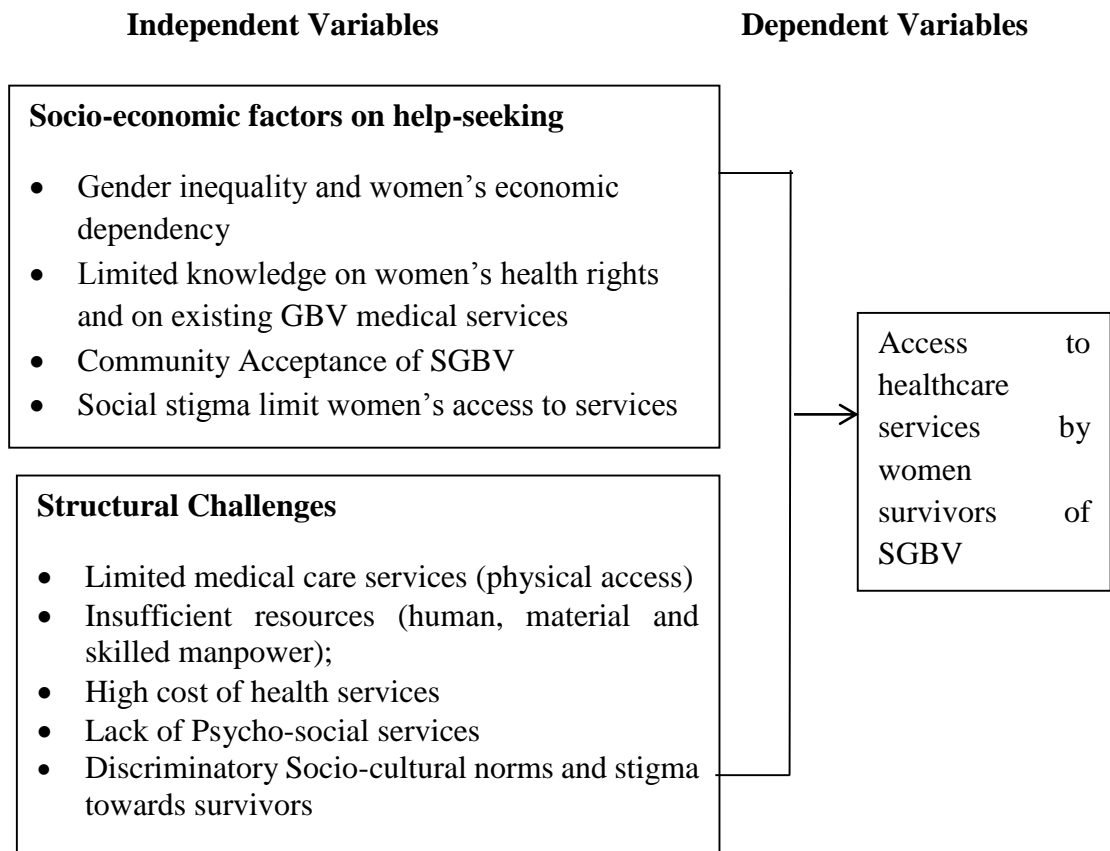
When the woman is able to narrate what she has gone through in seeking health care after undergoing SGBV and expose her subjectivity, this experience provides her the ability to change the meaning of her suffering, overcome the perceived submissive condition to the violence and hence demand for services from the existing sources of help.

2.5.2 Conceptual Framework

This study conceptualized that the interplay between socio-economic factors and structural challenges that women face in medical systems influence their help-seeking practices in Kibaha District, Coastal Region. The independent variables are therefore, socio-economic factors that influence women's help seeking behavior including public, perceived and self-stigmatizing attitudes on

sexual violence; women's ability to recognize that they have a problem; to be aware of where to seek support and the willingness to seek out and disclose to medical professions the aftermath of violence. Furthermore, the structural challenges include factors that appear to not only create help seeking barriers among women survivors of SGBV but also limit their access to appropriate health care. This includes the systematic factors that reduce the capacity of health systems and healthcare providers to offer comprehensive medical care to women's survivor of SGBV.

The dependent variable is the access to healthcare services by women survivors of SGBV. Ideally, effective health support system is supposed to increase survivor's help-seeking practices and easy accessibility of health services in Kibaha District. However, this could be hindered by women's negative experiences on help seeking process and the social, economic and structural challenges women survivors of SGBV face in utilizing the existing medical sources (health facilities).

Figure 1: Conceptual Framework

3.0. CHAPTER THREE: METHODOLOGY

3.1 Introduction

This section describes the research site, research design, study population, sample and sampling procedure, data collection methods and as well data processing and analysis. The section concludes by discussing the ethical considerations that guided the study.

3.2 Research Site

Kibaha District Council is among the seven district councils of Coast (Pwani) region and was established on 1st January 1984. The name Kibaha comes from the word “Kibaha”, a Zaramo word meaning “it is here”. The District is located in eastern part of the coast region and shares borders with Bagamoyo district council in the North, Kibaha town council in the East, Kisarawe district council on the South, while Morogoro region (Morogoro rural) lies on the Western side of the district council. The district council headquarter is at Kibaha, 45km away from Dar es salaam City, also it is the Coast Region’s headquarters.

The district council has an area of 1,630 km². Administratively, the District has 3 divisions which are Mlandizi, Kibaha and Ruvu and 11 wards namely Janga, Mlandizi, Kilangalanga, Ruvu, Kikongo, Magindu, Gwata, Kwala, Dutumi, Soga and Bokonmmemela. The wards are further divided into 33 villages and 53 *Mitaa* (streets) as the smallest subdivisions in which households in which households are located.

The population of Kibaha District Council has experienced significant growth. According to the 2012 Population and Housing Census, the district had 70,209 (34,515 Males and 35,694 Females) as compared to 53,411 inhabitants counted in 2002 Population Census resulting in a big increase of 16,798. The main economic activities undertaken include agriculture, industry and trade, livestock keeping, bee keeping, fishing and forestry. Few residents are engaging in business, mostly petty shops and market. About 75 percent of Kibaha District and Pwani regional economy at large comes from agricultural sector. The sector is however, dominated by smallholder farmers who grow cash crops, and most of them do not practice improved agriculture and as a result, the agricultural yields are relatively low. Per capital income is generally low, and at least 48% of Kibaha residents are living below the poverty line of one US dollar a day, therefore, poverty prevalence is quite vivid (Prime Minister's Office, Regional Administration and Local Government (PMoRALG), 2015).

The mode of health service delivery in Kibaha District Council just like other councils is based on curative, preventive and promotive health care and rehabilitative services provided by a total of 26 government owned health facilities; which is one rural health center and 25 dispensaries that address common health conditions, and refer complicated cases to higher levels particularly Tumbi referral hospital. Among those facilities, only two (Magindu Dispensary and Mlandizi HC) provide clinical management of SGBV survivors. Moreover, health deliveries at the community level is mostly facilitated by community based actors including traditional birth attendants, community health

workers and home based care providers whose role is to provide health promotion, preventive and curative services as well as attend to social welfare issues at grassroots, also in areas where distances to health facilities is a problem (Council Comprehensive Health Plan, 2015/2016).

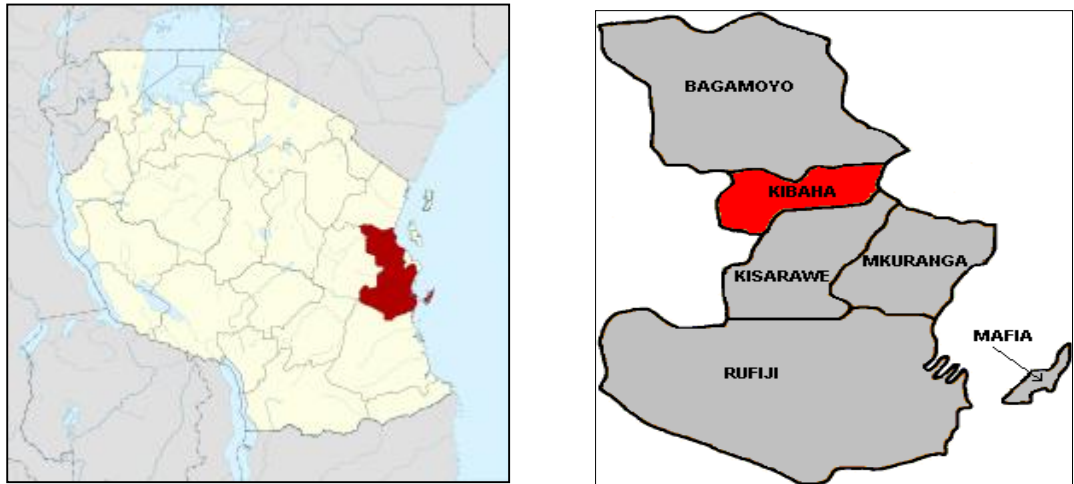
Transport services are also not reliable since all the roads serving rural villages are earth and only few are graveled which makes most places inaccessible during the rainy season especially in Magindu, Kwala and Ruvu wards. Transport and communication is thus a very severe limiting factor to the efficient health services delivery in the district.

In Kibaha district, women are underprivileged as compared to men in terms of education, property ownership and earnings. The literacy rate is estimated to be 79% of which 73% are women and 85% are men (NBS, 2011). There is no dominant tribe in Kibaha District, but some of the ethnic groups in the district are Wakwere, Wazaramo, Wandengereko and some immigrant Maasai and Sukuma (known as Wakwavi). Most of the communities follow patriarchal kinship pattern whereby men dominate the decision making power in all affairs concerning family health, production and income. Culturally, women are considered to have inferior status and least influence on decision making even in relation to their own health and sexual relationships.

Most of coastal communities are practitioners of Islamic and Christian religions. Marriage is highly privileged, and polygamy is highly practiced even though the practice of multiple sexual partners is condoned. SGBV including sexual violence is prevalent due to the discriminatory cultural practices, as 14% of women aged 15 to 45 have experienced physical or sexual violence in their lifetime. According to the Crime Report of 2015, a total of 513 offences against persons were reported in Pwani region whereas the frequently reported Sexual abuse offences are rape (339), unnatural sexual offences (53) and defilement (1) (Tanzania Police Force & NBS, 2015).

In responding to SGBV cases, the council has been collaborating with non-governmental organizations (NGOs) including KIKODET, Family Health International (FHI), Plan International and WAMATA to increase accessibility of health, psychosocial and related services for those most in need so as to improve their social wellbeing and enhance the protection for vulnerable groups in society. Furthermore, the district involves community in preventing SGBV in the grassroots through social VAC committees that were formed at the village, ward and district levels. The main responsibilities of these committees among others are to identify cases, assist survivors and make referrals to police and medical providers. Equal representation of women is prioritized in committees.

Figure 2: Map of Tanzania showing the location of Pwani and Kibaha District Council



Source: URT Government Website – Tanzania.

3.3 Research Design

This study adopted the exploratory design with the use of majorly qualitative methods to collect, analyze and present data. These methods include Focus Group Discussions, In-depth interviews, case narratives and Key informant interviews. The data was collected in Kiswahili language and later translated to English and analyzed according to the themes guided by the study objectives and presentation has included verbatim quotes to amplify the voices of the informants.

3.4 Study population and Unit of Analysis

The target population for this study was women who have experienced sexual violence in Kibaha a peri-urban district in the coast region. The unit of analysis

was an individual woman survivor who has had some experiences in seeking medical care after an episode of sexual and gender based violence (SGBV). The study focused on women in reproductive age as various researches show that the experience of violence increases when women reaches reproductive years (UN, 2015).

3.5 Sample and Sampling Procedure

Due to cost and the limited time, a small sample of 50 women survivors of sexual and gender based violence were purposively selected. The sample was drawn from the three wards that were also purposively selected based on the distance to the district headquarters, the capacity of health facilities to offer comprehensive service to survivors and the type of the ward (rural/urban).

The beginning point in the recruitment process was the village heads and women survivors 'support groups that were requested to assist in identifying women who have at some point in their lives reported any form of violence. From the few first cases, women were requested to assist in identifying others through a snowball process especially those who are in survivor support groups. Part of the inclusion criteria was the willingness of the individuals to share their lived experiences.

3.6 Data Collection Methods

3.6.1 In-depth Interviews

In-depth interviews were conducted with primary population "the survivors" from three wards in KDC using the in-depth interview schedule that consisted of

open and close-ended questions. The information was tape recorded and then subsequently transcribed. Giving them new identities through codes concealed identities of people. This teased out the individual experiences of violence, the challenges faced with seeking medical care and subsequently what they think would be the best way out in assisting people in similar circumstances.

3.6.2 Key Informant Interviews

A total of seven (7) KIIs were conducted with district health planners and service providers to get their expertise details on district's SGBV response and their opinions on how medical support and services are offered. These include district gender focal person from the District Community Development Office; District medical officer from the District Medical Office of Health; and one program officer from KIKODET- an NGO that provide medical support and services to GBV survivors in Kibaha district. Moreover, four interviews were done with health care providers from Tumbi One stop Center, Mlandizi health center and two dispensaries-Magindu and Kwala. The informants were purposely selected to give their opinions on how the management of survivors is done at the respective facilities. All interviews were done in Kiswahili using the KII interview guide.

3.6.3 Focus Group Discussions (FGDs)

A total of 3 FGDs with community members (men and women separately) and one with representative of members of Village and Ward multi-sectoral committees on violence against children were conducted. These committees are

responsible bodies in responding to GBV cases in the community. The first FGD (with Female) had 10 participants, the second (Males) had 9 participants and the third had 8 participants. The criteria for selection of the participants in the FGD was that one had to be a community member which entailed being a permanent resident in the particular ward and should not be below 18 years of age.

The main aim was to understand community-level perceptions, attitudes and the prevailing cultural practices that condone and normalize SGBV; knowledge on the existing SGBV support systems and their likelihood of utilizing the available medical services in Kibaha district. Also, these discussions captured barriers on access to medical services from the point of views of males and females members of Pwani community, regardless of their experience of violence and how best to address these issues.

3.6.4 Case Narratives

A total of two case narratives were conducted with women survivors who were willing to share their lived experiences in regard to the abuses encountered and what they had gone through in the process of seeking medical care in the existing support structures.

Case narratives were important in this study as they provided a richly detailed exploration of individual's own accounts of their lived-experiences, thereby helping in achieving a holistic understanding of the perceived and the actual

barriers to seeking medical care from the women survivors of SGBV in Kibaha district.

The informants for the case narratives were purposively selected based on their past experiences with sexual abuse and comprehensive medical GBV services especially in the research site. A case narrative interview schedule was used to guide the interviews (Appendix IV).

3.7 Data Processing and Analysis

The qualitative information generated from this study was coded, interpreted and then analyzed along the study themes. This involved categorizing responses from interviews and open-ended questions in the interview guides into themes as outlined in the study objectives. Moreover, all emerging themes were documented. The presentation of data involved thick descriptions and where necessary, verbatim quotes have been used to amplify the voices of the ^{different} shades of informants and FGD participants.

3.8 Ethical Considerations

The procedures for the study observed the WHO ethical guidelines of research on violence against women (Watts et al., 2001); that emphasizes on prioritizing the dignity, confidentiality, privacy and safety of both the participants interviewed and the fieldworkers carrying out the study.

A research permit was attained from the Commission for Science and Technology Tanzania (COSTECH) and ethical clearance from Medical Research Coordinating Committee (MRCC) which is under the National Institute of Medical Research, the two authorities that have been consigned with such powers in the country. A request for permission to carry out the study from Kibaha district authority was also done in time.

Sexual violence is a sensitive topic in nature, therefore to ensure voluntary participation; individual informed consent was obtained from the participants before the interviews. The informants were informed on the objectives and the procedures of the study; potential risks and benefits of their participation and the mechanisms and limitations of confidentiality was stated very clearly. A consent form (Appendix VI) was used to obtain the approval of the informants. Anonymity was ensured through use of pseudonyms instead of their real names and non use of direct or indirect identifiers in the report.

Furthermore, informants were assured of the confidentiality of the information given as it was to be used exclusively for academic purposes; and that there was no compensation for participation in the study and that they were at liberty to withdraw from participation at any stage of the interview process if they felt uncomfortable. All records were kept in a secure location at all times.

It is hoped that feedback sessions could be organized to share the findings with the women survivors of sexual violence and Kibaha community and that the

results of the undertakings will be available in the University Libraries. To the larger scientific community, attempts will be made to publish the work in refereed journals.

3.9 Challenges Encountered in the Field

Scarcity of resources affected the timing for data collection as the number of days had to be reduced from 21 to 12 days so as to meet the costs. Although there was official letter to introduce the researcher, some respondents were reluctant to share their experiences due to the complaints that there had been a tendency for some people/NGOs to collect information for their personal/organizational benefits without regard to the informants.

Due to absence of supporting groups for survivors of sexual and gender based violence, health facilities were used as entry points to get into contact with the informants. This process had a short fall in ease with which the survivors could be traced. The records at the facilities lacked certain details like survivors addresses.

There was the problem of Language barrier especially with Wamaasai and Wasukuma. It was difficult for them to understand some terminologies in the sexual and gender based violence world, thus further descriptions were used that had the possibility of distorting the meaning. All the above were overcome by ensuring clarity and getting several people to translate a term to the local equivalent.

4.0 CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter presents the findings and observations of the study on sexually abused women in accessing medical care in Kibaha District. The total number of Respondents is 42. The analysis of the information obtained is as presented herein under.

4.2 Demographic characteristics of the Participants in In-depth Interviews

As it is shown in table 1.0 below, majority of participants (88%) were young women below 30 years whereas the adult women between 31 and 49 comprised only 12% of all respondents. Majority of respondents (80%) were not married, and about half of them have got primary education level where as 29% have ordinary level of education and 21% did not go to school at all. With regard to employment status, about 64% of women are unemployed whereas others are farmers, pastoralists and self-employed. Almost all the respondents (91%) have either no children or have only one child whereas 7% have two to five children.

Table 1: Demographic characteristics of the participants in IIs

Variable	N (Percentage)
Age	
15-20 years	23 (54.8%)
21-30 years	14 (33.3%)
31-49 years	5 (11.9%)
Marital status	
Single	35 (83.4%)
Married	3 (7.1%)
Divorced/separated	4 (9.5%)
Family Dependents	
Below 2	38 (90.5%)
2-5 children	3 (7.1%)
5-8 children	1 (2.4%)
Educational level	
Primary	21 (50%)
Secondary	12 (21.4%)
Not educated	9 (28.6%)
Employment Status	
Unemployed	27(64%)
Employed (Government and Private sectors)	4 (10)%
Self employed (small business)	3 (7.1%)
Farmers	7 (16.7%)
Pastoralists	1 (2.4%)

Source: *Field Data, 2016*

4.2.1 Community Perceptions of sexual violence in Kibaha

The study sought to gauge the subjects' understanding of sexual violence in their community as a type of gender based violence, who are the main perpetrators, how does the community see/perceive a survivor of SGBV as well as cultural justifications of SGBV.

Sexual violence is a new topic for discussion in Kibaha as it is observed from 43% of respondents. About 57% of respondents who tried to define sexual violence, mentioned some acts, which involve coerced sexual intercourse by a stranger or someone known or related to the victim without the victims' consent such as rape and defilement; however their definition is limited to "completed sexual acts" and not "attempted acts".

Consensus from focus group discussions with males in Kwala ward pointed out that SGBV constitutes all unlawful and unaccepted sexual acts against a woman's wish that cause bodily harm and violate her rights. However, rape in marriage is not considered violence as one participant commented:

"Males have a right to sex in a relationship"

Another participant noted thus:

"wanawake wanabakwa ndani ya ndoa ila hawasemi kutokana na mila na desturi zetu, kwani tendo la ndoa haki ya mume na wajibu wa mke kutimiza muda wowote..."

[Women are raped by their spouses but they keep it to themselves due to our culture/traditional norms].

For majority of women in this study drawn from FGDs and in-depth interviews; sexual violence happens when the woman does not give any consent to the sexual activities. In this case, rape, forcing spouse for sex against their wishes and other forms of physical violence as beating and pushing by opposite sexes amount to sexual violence.

4.2.2 Forms and spheres of SGBV in Kibaha

Rape among adolescents and women is a common form of sexual violence reported by majority of informants and participants of this study, however very few cases are documented in the formal structures. Other forms of GBV which are rampant in KDC are physical violence mainly wife beating and harmful cultural practices that include early marriages and early pregnancies, FGM and denial of education.

“The leading form of violence is Psychological even though it is not documented, followed by physical and then sexual violence. According to the available data, 1 in every 3 girls and 1 in 7 boys experience SGBV in the district” (KII with an officer from NGO-KIKODET).

“Majority of rape cases are reported from urban wards such as Mji Mdogo Mlandizi, but are underreported and undocumented in rural wards particularly among the pastoralist community i.e. wamang’ati and Wasukuma from Kwala and Magindu wards where people are ignorant on women’s rights” (KII with district gender focal person).

4.2.2.1 Perpetrators of sexual violence

Participants in this study agreed that violence is overwhelmingly directed towards women and girls as the subordinate gender characterized by power imbalances and other inequalities, and males are the main perpetrators of SGBV and other forms of GBV. Many SGBV acts were reported to happen in domestic sphere, inside what should be the most safe such as at homes (76%) and schools (12%), while very few acts (7%) occur in public such as on the roads. The main perpetrators of SGBV reported to be male partners, strangers and teachers.

4.2.2.2 Causes of sexual violence in Kibaha district

Culture plays significant roles in perpetuating gender inequalities and fueling sexual and other forms of violence among women in Kibaha. These socio-cultural practices contribute both to women's vulnerability and to their lack of autonomy and agency to respond to threats of violence.

“Certain cultural practices such as Unyago expose women to violence. For instance, young girls are taught to be submissive to their husbands, and sex is considered a husband's right and a woman's responsibility (among other domestic responsibilities) and that denying a husband his conjugal right is forbidden” (A 42 years woman in FGD in Mlandizi).

Moreover, after *Unyago*, the girl is considered a grown up person and she has to be responsible for her own life, nobody takes care of her anymore (financially, socially). Thus girls are exposed to violence (*mazingira hatarishi*) at very young age when they still cannot make right decisions on their own.

A 32 male participant in an FGD in Kwala ward noted thus:

“In Pastoralist communities of Masaai/Mang'ati and Sukuma, women's inferiority is the order of the day. To them, a woman is a man's property and that she doesn't have any say on any matter pertaining to her and family life. Rape, wife beating, FGM, early marriage, denial of education and other forms of violence are common”.

For majority of women who participated in this study, it was revealed that power inequality between men and women is a major cause of SGBV among Pwani communities. The subordinated status of women in social, economic and legal spheres reduces the chances for them to get support in case of violence.

Most participants in FGDs were of the opinions that sometimes survivors can be at blame for provoking men to abuse her sexually. Both men and women cited some circumstances and behaviors that are believed to provoke rape such as wearing short clothes, taking alcohol and accepting gifts from strange men,.

“Sometimes these ladies are the ones to blame, (if) you find a lady wearing indecent cloths that exposes her body. They cause men to look, so the man gets that lust and rape her”- (Female participant in FGD)

The above statement indicates community acceptance and justifications of sexual abuse, whereas rape is considered the woman’s fault, suggesting that she has seduced the man into an illegal act. In this scenario, the usual community response tends to overlook the consequences and harm the woman had gone through and seeks to redress rather to blame and stigmatize her particularly for the shame brought to the family. This in my opinion is wrong as it violates women’s rights.

Other social factors include superstition whereby men are ordered by *wagangas* to rape their daughters/old women to get wealth. Also, traditional dances which are played until mid night as well as long distance to social services such as schools, markets, health facilities and shops act as catalysts to the vice. Nevertheless, poverty and economic dependency forces some women to resort to transactional sex where as men pay very little money that cannot recompense the dignity the woman has lost in the name of survival.

“Some girls and women desire for high life and luxurious things such as mobile phones, expensive cloths which they cannot afford, so they start taking money from different men in exchange for sex, and as a result, men conspire to do filthy games to teach her a lesson ” –(a male focus group participant).

Although it was not the interest of this study, participants in the focus groups revealed the occurrence of sexual violence acts among adolescent boys in their community. Most participants have heard or witnessed the cases of young boy been raped, and most shockingly by their fellow classmates or playmates. As it has been observed in the field, sexual abuse among boys particularly in school environments is in the increase and thus warrants further research and interventions.

4.2.3 The cultural justifications of SGBV

Throughout the discussions, participants describe various traditional norms and beliefs that legalize the acceptance of sexual and gender based violence among Pwani communities. This includes “bride price” in marriage institution.

“A husband has got all the rights over a wife whom he has paid too many cows or a lot of money in bride wealth. Therefore, a wife has to submit to her husband in any circumstances including non-consensual sex”.

As a retort to such views, one participant posed the following question:

“How could he be guilty of rape upon his wife since she has already given her blanket consent in their mutual matrimonial contract?”.

Furthermore, Sex matters are considered private matters; a woman cannot report her husband to strangers (formal mechanism) rather than respected family/community members (informal mechanism).

However, there was no consensus particularly among women on the belief that a wife cannot retract the matrimonial agreement and that it is her duty to submit anytime the husband needs his conjugal right. But the normative nature of SGBV acts increases its acceptability as part of relationships and marriage. A female participant in an FGD raised the issue of giving “consent in sex”, and that without it is rape.

“Rape is not only being forced to have sex with a stranger, it is even when your sex partner decides to have sex with you without your consent, and this should not be accepted as even us women we have the right to choose when we want to have sex and how to do it”

4.3 Experiences of women survivors of sexual violence in seeking medical care

This section describes the different experiences of women survivors of sexual and gender based violence in seeking medical care in the community.

4.3.1 Survivors Knowledge on the formal medical support systems

The study aimed at mapping out the existing medical support systems in Kibaha district and assessing their utilization. Findings from this study shows that formal structures for SGBV medical support that are well known to the majority of community members are health facilities and police stations, community health workers, NGOs and CBOs such as KIKODET and Plan International. Conversations with community members indicated that many of the existing community structures such as village and ward leaders, district level officials (e.g. social welfare officers) and special committees for children (Most Vulnerable Children committees) are rarely utilized and subsequently Gender

and Children Desk are not known. Moreover, there are no drop in centers and safe houses in the district.

“ *Kwa hapa kijijini kwetu (Kwala) mara nyingi wanaobakwa hupelekwa kituo cha polisi halafu zahanati kupata matibabu, sijawahi kusikia dawati la kijinsia. Ila pia Plan International nimesikia wanashughulikia masuala ya ukatili wa kijinsia..* ” [.. In this village (Kwala), in most cases the survivors of rape are being taken to police station (to collect PF3), then after they are taken to dispensary for treatment, I have never heard of gender desk. Also, I once heard of Plan International taking care of gender based violence”] (female participant in case narrative).

This was substantiated by member of the multi-sectoral committee on violence against women and children;

“... *tangu kamati yetu iundwe hatujawahi kupokea kesi ya ubakwaji ama unyanyaswaji wa kingono kwa wanawake, kiufupi haijulikani na wananchi, nafikiri tuanze uhamasishaji kupitia mikutano yetu ya kijiji* ” [since its formation we (committee members) have never received any case on sexual abuse against adult women. In short, community members are not aware about the committee’s role in response to sexual violence against women; I think we need to sensitize community through village meetings].

Despite their knowledge on where to get support, there is confusion on the procedures to follow while seeking medical support particularly between health facility and police station. Findings show that 57% of respondents reported the incidence to Police Stations so as to get a PF3 form before seeking medical attention, 26% went straight to health facilities whereby about 5% just reported the matter to gender desks and other 5% to general police stations without seeking medical care.

“..*imekuwa ni kawaida kwa madaktari kutaka uonyeshe PF3 ndio wakutibu ikiwa umebakwa, kuumizwa ama umepata ajali*” [...it is a requirement for a victim of sexual violence, physical injuries or accident to submit a PF3 form before they receive care” (A participant in FGD with committee members in Magindu).

4.3.2 Survivor Utilization of existing medical care

Since the interest of this study was to assess the extent to which survivors of SGBV utilize the available GBV medical structures, majority of women survivors (81%) seek medical care at nearby facility (immediate environment) and then after referred to higher level facilities for further treatment, while 7% did not report the incidences to any formal mechanisms.

4.3.2.1 Utilization of medical care by age

Decision to utilize service is influenced by various factors including type of violence, survivor's age, as well as what has motivated her to seek care. Findings from this study show that most survivors of sexual violence seeking medical care are young women from 14 to 30 years (88%). Adult women from 31 to 49 years who experience sexual violence do not seek support from formal mechanisms (they comprised only 12% of all respondents).

“It is easier for a young woman who is 16 years old to disclose rape because she will get full support from parents, friends, close relatives and even the police... but for an adult woman (above 35 years),it is rare; as she will be afraid as she will be humiliating herself”-(Female FGD participant in Kwala).

“Approximately 30% of survivors of violence seek medical and/or legal services, but majority of them are young girls (between 15 and 17 years). It is very difficult for an adult woman (35 to 45 years) to disclose their victimization to medical personnel.” (KII with officer from an NGO).

Health care providers interviewed reveal that survivors of SGBV attend health care facilities in the most extreme cases i.e. when they are badly injured. Due to lack of proper skills, health care providers do little more than treating the physical injuries resulting from the assault. Furthermore, various key informants

revealed that, more likely, survivors of SGBV do not disclose the injuries particularly when abused by husbands and partners. Usually, adult women are ashamed and deny that they are being abuse.

Various reasons as to why adult women do not seek medical care were mentioned including limited understanding on where, how and when to seek help, lack of confidence, long distance to support systems i.e. health facilities (Tumbi GBV one stop center) and courts; lack of confidentiality among service providers, poverty and illiteracy among women survivors. Moreover, economic dependency and poverty are among the factors that influence utilization of medical services as the majority of women who did not seek support (79%) said they would love to seek care but they could not afford the high costs of services.

“Fikiria umbali kutoka hapa (Magindu) hadi Mlandizi (kituo cha afya); barabara ni mbovu na usafiri ni wa shida hivyo gharama ni kubwa sana kwetu kuweza kumudu, mara nyingi wanaobakwa wanaamua kutoripoti ukatili na kujitibia nyumbani” [...just look at the distance from here (Magindu village) to Mlandizi (health centre), the infrastructures are very poor and transportation is too expensive for many of us (women survivors) to afford, thus in most cases, survivors decide to not disclose their victimization and treat themselves at home” (Participant in case narrative in Magindu).

4.3.3 Type of Medical care available to survivors of sexual violence

The clinical management of survivors is done at health facilities and the law requires that health care facilities at all levels to provide a minimum package of services for GBV survivors which include informed consent, history taking, physical examination, treatment of injuries, STI screening and treatment, HIV

PEP, basic psychosocial assessment and counseling, timely referrals and other community based services as per survivors' needs.

Findings revealed that all dispensaries in KDC offer basic level of care to survivors of SGBV and only some cases are referred to Mlandizi health center for additional services, with exceptional of Magindu dispensary where all GBV services are offered at Care and Treatment Center. For cases which either are more complicated or require more specialized care, they are referred to GBV one stop center at Tumbi regional referral hospital.

Despite the importance of forensic evidence on survivor's access to justice, findings from the field show that collection of forensic evidence is not done as required due to the absence of forensic kits in all the facilities surveyed. Also, provision of medication such as antibiotics depends on the availability but counseling; emergency contraceptives and PEP are provided in every facility. The inconsistency and inadequate services provided to survivors have negatively impacted survivors' help seeking behavior as they are not sure if they will get services they require in timely manner.

4.3.3.1 Trained Human Resources

Trained health care providers are important in delivering comprehensive and quality care to survivors of SGBV. Despite their importance, findings from this study revealed a huge shortage of skilled personnel to deliver GBV services and

this may inadvertently put survivors at further risk of misdiagnosis or inappropriate care.

In Tumbi, there are 13 staff members who are Social Welfare Officers (2), Police Officers (3) Medical Doctors (4) and Nurses (4). In Kwala dispensary, only one out of the available seven staff had received specialized trainings on GBV (facility in charge), whereby in Magindu dispensary, none of the staff is trained on GBV management. A member of staff at the facility noted thus:

“There are no special trainings on GBV; we are just using some basic skills from school” (One of the healthcare providers commented).

The district has no protocols that guide healthcare providers on how to appropriately manage GBV survivors and how start up service delivery points. Moreover there are no guidelines for healthcare managers and providers to identify and quickly mobilize the financial and material resources for GBV service delivery points.

The study further revealed that there is no any designated GBV program in KDC since GBV is not taken as a priority by planners. All GBV activities are included under other activities in health plans. Further, most gender activities are incorporated in community development plans under the social welfare but in most cases, they receive no funds since the budgeted amounts are transferred to other activities or are being dropped out due to budget insufficiency. There are no enough skilled health providers in the district as few staff had received

trainings for the past two or three years and no recent GBV trainings were conducted. The GBV training that had been done were conducted by partners in collaboration with KDC, but all expenses were catered for by donors i.e. Plan International and KIKODET. Less district efforts in putting in place conducive environment for GBV services have greatly contributed to the deterioration of post violence healthcare to survivors of sexual and other forms of gender-based violence in the district.

4.3.3.2 Medicine and medical supplies

In order to provide comprehensive care to GBV survivors it is a pre-requisite for all health facilities to have all the necessary supplies including rape kit that includes post-exposure prophylaxis (PEP); emergency contraception (EC); items for collecting forensic evidence (syringe, speculum, empty sterile bottle, and high vaginal swab); sterile gloves; sterile swabs; and medication for symptomatic conditions, resuscitation equipment, Sterile stitches and dressing trays, Sanitary supplies as well as Pregnancy test kits.

However, findings from the field revealed that about (90%) of facilities where data was collected from reported to have frequent stock outs of essential medicines and medical supplies including test kits for pregnancy and VDRL (these were not available during the time of interview in Kwala dispensary). None of the facility has got a pre-prepared rape kit therefore; doctors collect these items on a tray which is not a recommended way. Moreover there is a shortage of supplies and equipments for preventing and controlling infection.

Stock outs of treatment for STIs were reported in Kwala and Magindu dispensaries whereas PEP and EC, such as combined oral contraceptives, “morning after pills”, Progesterone Only Pills (POP) appeared not to be a problem in all the facilities.

With regard to administrative supplies, none of the facilities use the standardized forms to obtain a thorough and systematic history related to survivor’s general information i.e. names and contacts, the nature of the violence and consequences, gynecologic history, mental health status as well as past medical history.

The absence of the consent Forms, GBV registers and a GBV medical form have negative impact on the proper medical management of survivors since the proper history taking assists service providers to establish what kind of services the survivor requires. Moreover, proper history taking, examination, and documentation of survivors’ details provide the crucial links among the occurrence, the survivor, and the healthcare and criminal justice systems.

“I was neither given information on the available treatment options nor signed any paper (informed consent), they just asked me about the incidence and then sent me for laboratory tests” (A 44 years old survivor in Kwala).

4.3.4 Survivor’s satisfaction with services received

The study sought to gauge survivors’ experiences on the quality of care and their satisfaction of services they received at health facilities after reporting the abuse. Participants were asked whether they were satisfied with the quality of services received at health facility they have reported to. On the quality of care, the main

components assessed were privacy, time spent as well as how healthcare providers interact with the survivors.

As it is shown in **Figure 3** below, majority of the respondents (67%) said they were “fairly” satisfied with the services received since they had no other option but complained about privacy, long waiting times, high costs of services and long distance particularly when referred to higher level facilities including Mlandizi and Tumbi one stop Center.

“There is no special room for us (survivors of violence) we are just sharing the same consultation rooms with normal patients, and as you know the way those rooms are small and congested”(A 30 years survivor in Kwala).

Figure 1: Survivor’s Satisfaction with Services Received



Source: Field Data, 2016.

4.3.5 Community support towards women survivors of SGBV

Majority of the Respondents (73.8%) hold the view that support from the society to the victims of sexual violence is not enough. In most cases, the society

stigmatizes the survivors of sexual violence by calling them names and blaming them for the act. However, very few women (9.5%) reported to have received support from the society but this is mainly to young girls who have been raped. The type of support received included guidance on the legal remedies and sympathizing with the family and comforting the survivor.

Survivors were asked on how they cope with the situation and majority of women survivors (55%) reported to have isolated themselves from the community whereas others resorted to relocating their residences to other areas in a move to curb stigma from the society.

“The stigma that goes with being a sexual and gender-based survivor is too traumatic that most deal with it through isolation or relocation to new areas where you are unknown” (A survivor who relocated).

4.4 Challenges faced by sexually abused women while seeking medical care

Despite the government’s efforts to enhance the availability of services to the community, access to and utilization of services has been a problem particularly in Kibaha district. Findings from the field show that majority of women (74%) have been experiencing various legal, medical, financial and socio-cultural challenges while seeking medical care from the existing health care systems in the district. Only 26% of respondents reported not to have encountered any difficulties while seeking medical attention after the abuse. Below are more

details on the challenges women survivors have experienced in the process of seeking medical care in Kibaha district.

4.4.1 Lack of awareness on women's health rights

Limited knowledge among women about their basic human rights including the right to live free of violence and to seek immediate health care and justice in cases of violence is one among the most essential barriers identified by participants in this study and this has serious effects on the services utilization. Furthermore, a lack of knowledge about the 72-hour window for reporting violence may also limit survivors from seeking immediate medical care.

Approximately, about 12% faced cultural based barriers such as the stigma, denial and lack of support from the victim's family as some of them influence the victim to shield the perpetrator from legal action.

4.4.2 Discriminatory cultural Norms and Social stigma as a barrier to medical care

Gender-based violence, sexual violence in particular can not be isolated from gender norms and social structures that put women at higher risks of violence. These norms, traditional beliefs and social institutions such as family and marriage in almost all cultures of existing tribes in Pwani, legitimize and perpetuate violence against women. Due to their impoverished status, women are considered "weak" and men as sole providers for their families, thus all decision-making powers are vested upon men. On matters sex, women are

expected to be submissive since it's the husband's "individual right" therefore, the concept of mutual consent is virtually non-existent.

"Sexual violence acts are highly accepted and tolerated even by women themselves and women rights on "their bodies" are overlooked and their decisions are taken for granted" (A female FGD participant).

The subordination of women to men particularly in the pastoralist and Swahili communities in Kibaha culminates from the generational stereotypes which are deep-rooted in different levels of societies.

"In Masaai "wakwavi" community, a woman is communal property, no Massai woman is married to single Morani, and any Morani can have sex with her, as long as he stabs a "mkuki" on the ground outside the woman's hut" (said a participant in the FGD with members of GBV committee).

Additionally, there is societal tendency to blame women that they provoke their own victimization, and sometimes community tends to protect the perpetrators. The societal cultural stigma greatly impact survivor's help seeking as women internalize negative beliefs about the abuse as true of the self and also the anticipation about how will community respond once they know about the abuse (e.g denial, shaming)

Since sexual and gender based violence in part evolves from women's insubordinate social-economic status, the normalized environment of sexual violence among Pwani communities, the culture of secrecy as in "sex is regarded

as a taboo topic of discussion” and lack of support from men makes it extremely difficult for women to not only disclose to service providers but also seek remedies from the community as well as legal and justice systems.

4.4.3 Lack of economic empowerment

Due to their low economic status, most of the women in Kibaha district rely on men for their sustenance, and, thus increase their vulnerability to partner violence. Due to the higher economic status, men make unreasonable demands, which if unmet can result to violence such as forced intercourse and battery. In spite of their knowledge of violence, poor women do not report to the formal mechanism including police and health facilities as it is high-lighted by a female participant in an FGD in Kwala ward:

“He is the one providing for the family, if I take him to court, who will take care of the children, as you can see am just a house wife!!”

Moreover, women’s economic conditions forces them engage in exploitative sexual relationships so as to obtain basic needs including food, shelter and clothes for their survival. Women’s economic powerlessness in intra-household resource allocation and decision-making limits their power to access health care services. The low self-esteem, related to a low status, reduces woman’s agency and determines her options to resist violence as the social welfare Officers at Tumbi One stop Center commented:

“Poverty affects women survivors to access appropriate support, for instance when the survivor is referred for further treatment in One stop center, and the family do not afford the high transport costs and other

emerging costs, thus, the only option is to neglect survivor's health needs".

4.4.4 Inaccessibility of services

Access to medical health care can be looked upon in three components, survivor ability to gain the entry point into medical systems, having a physical access to a GBV service delivery point and finding a skilled health care provider whom can communicate with a survivor in a friendly manner and develop trust among them.

4.4.4.1 Distance as a barrier to access to health care

Physical accessibility of health facility is an important factor in the utilization of medical care. Despite its importance, findings from the study revealed the disparities in physical accessibility of health care facilities in Kibaha district particularly higher-level facilities where additional and specialized services are available.

"We have dispensaries in almost every village but majority of them lack medical staff and supplies' thus they do not have the capacity to provide even some basic emergency services for survivors, therefore GBV survivors are referred to Mlandizi and GBV one stop center at Tumbi referral hospital, that is more than 90 kilometers away"(KII with a representative from MMOH).

The unavailability of medical care in the nearby area where the abuse has occurred can make it expensive for survivor to seek immediate or follow-up care.

"Waliniambia zahanati yetu haina uwezo wa kutibu wagonjwa wanaobakwa hivyo wataniandikia niende Mlandizi nikapatiwe vipimo na matibabu mengine, kwa vile ni jioni na hakuna usafiri ilibidi tungojee kesho yake asubuhi ndio twende.." [I was told (by the nurse) that the facility is not in capacity to offer services for survivors of sexual violence, so we have to go to Mlandizi (health center) for examination and additional treatment, but as it was already evening there were no

buses to take us to Mlandizi, so we had to wait until the following morning].

A lack of capacity within SGBV service delivery points limits survivor's access to appropriate and timely care. When referred to higher-level facilities that are relatively far, survivors may not be financially able seek care until days later, lessening the opportunity to address the medical consequences of sexual abuse within the required time.

4.4.4.2 High cost of services as barrier to access to health care

Service affordability is one of the major factors to consider in ensuring accessibility of services to intended population. About 14% of participants complained about high costs of services in the sense that in some points they were required to either pay for laboratory tests or buy some medicines which they could not afford and also transportation costs when they are referred to higher level facilities such as Mlandizi and Tumbi One stop center.

[After the act, we took our daughter to the village dispensary but they told us to take her to Mlandizi health Center as they had no supplies; after getting there (Mlandizi HC) they did laboratory tests and gave her some medications. Surprisingly, she was given a referral to Tumbi One Stop Centre for further treatment. Just imagine, the girl had been raped and all she needs is immediate service, instead we were required to spend money travelling from here to there, we would rather opt for private facility” (A parent of 16 years old survivor).

4.4.4.3 Insufficient resources for GBV service

The District authority is accountable and responsible for the delivery of comprehensive healthcare services to the population in the district. The provision of quality services requires proper planning, budgeting and effective

implementation and evaluation of services. However, findings from this study shows that GBV services in KDC are inadequately resourced in terms of financial, human and material resources.

There is limited number of facilities that offer GBV services in the district as the existing ones i.e. Mlandizi and Magindu do not have enough spaces that ensure privacy for GBV survivors, and Tumbi One stop center is very far. Moreover, these facilities are generally not prepared and lack equipments and skilled medical personnel to offer GBV services particularly in forensic investigation.

Health service providers and health managers do not consider SGBV funding a priority. The district authority finances public health in general, without taking into account the exceptional circumstances surrounding SGBV as the district gender focal person noted:

“There is no special budget for GBV services from the district, the funds for medicines and supplies for instance are allocated under the general ceiling for medicines and supplies which is relatively little as compared to the district needs. As a result, our facilities experience frequent stock outs”.

Furthermore, there are no safe houses in the district instead they use “fit persons” to rescue children survivors although they (fit persons) don’t have enough skills on how to do the same. There is no vehicle for emergency services like rescuing survivors of violence, supervision and other activities, and hence limit the provision of services including rapid response.

4.4.4.4 Negative attitudes of health care providers toward survivors of SGBV

Healthcare providers are the first personnel to receive survivors of SGBV while seeking support, therefore they are obliged to show empathy and be sensitive, discreet, friendly, and compassionate when dealing with the survivors. However, findings from this study revealed that many doctors and nurses have got negative attitudes towards women who disclose their victimization to them. These attitudes include treating SGBV clients in disrespectful manners, use of provocative language and blaming women for their abuse. A mother of a 19-year-old girl survivor lamented:

“That doctor was so rude to us, he didn’t care of what my daughter had gone through and yelled out to us to narrate what happened to her and said ‘I have other important patients to attend to, my job is not only to see victims of rape, so I can do it or leave it’.

Another woman shared her experience of what a nurse told her:

“nyie wasichana mnajitakiaga wenyewe kubakwa”[you girls are responsible for your own rape”].

”Some medical doctors have bad interpersonal relations with GBV survivors and treat them disrespectfully and in a culturally inappropriate manner only because they are not trained on how to handle a survivor of GBV” (KII with gender focal person).

4.4.5 Lack of privacy at health facilities

As it is stipulated in the guideline (MoHSW, 2011), GBV services should be provided in quiet, private, easily accessible rooms near toilets. In a small facility

or where there is adequate space, healthcare providers shall create a private space to ensure privacy and confidentiality. However, lack of privacy and confidentiality has been the biggest challenge in almost all facilities surveyed and this reduces the quality of services since it increases the chances of survivor subjectivity to gossiping and shaming from other clients.

4.4.6 Unclear referral pathways

Participants of this study complained about the circuitous and tiresome referral pathways that neither prioritizes GBV nor responds to violence as emergency situation. According to them, referrals are needed at every point of service, whereby a survivor is required to narrate what has happened thus exposing them to potential re-traumatization and generally hampering access to care.

“We went to report to the village chairperson who couldn't help us with the letter to proceed to the police station at either Mlandizi or Chalinze for PF3 since there is no police post here (at Magindu). We then decided to take the victim to Magindu dispensary for clinical management” (A father of 19 years old girl survivor of rape in Magindu)

5.0 CHAPTER FIVE: DISCUSSION, SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.1 Introduction

This chapter presents detailed discussion of the findings in relation to other studies on the experiences of women survivors of SGBV and the challenges on their access to medical care. Summary based on the study objectives, findings are also presented in this chapter. Finally, the chapter presents the recommendations on overcoming the barriers to accessing medical care for the women survivors of sexual abuse.

5.2 Discussions

The use of qualitative methods approach allows for an in depth understanding of women survivor's lived experiences in seeking medical care (both negative and positive) as well as the challenges preventing them from accessing appropriate and timely care in Kibaha district.

SGBV was clearly perceived as a serious problem that is increasing in intensity. Subjects of this study define sexual violence as coerced sexual intercourse by a stranger or someone known or related to the victim without their consent particularly rape, defilement and forcing a spouse for sex against their wish. Moreover, majority of the participants do not perceive "attempted acts" and other acts such as uninvited touches by opposite sex as violence. However, forced sex in marriage was not considered rape by men and (some few women) who participated in the focus group discussions; and wives are supposed to be

sexually submissive to their husbands and both men and women acknowledged that a wife who refuses sex is at risk of forced sex or be beaten.

The study subjects also view sexual violence to be happening in both the public and domestic spheres, and women are seen as the main victims as compared to men; although young boys may also be victims of sexual assault among coastal communities. This finding confirms findings of earlier study by Keesbury et al., (2012) which showed that in Africa, approximately one in five women between 15 and 49 years (21%) experienced sexual violence at some point of their life. Additionally, UNFPA (2003) reported that more than 20 percent of women are abused by men with whom they live together.

Findings from the field suggested that the common forms of GBV handled at health facilities and one stop center are sexual violence, physical, intimate partner violence and some harmful cultural practices such as early marriages and early pregnancies. Rape, defilement and sodomy are common forms of sexual violence which were documented within these facilities. Young women (between 15 to 30 years) and children (mostly girls, but also boys) are the main service seekers in the district, and that adult women survivors rarely disclose their victimization to formal structures including healthcare providers. This finding substantiates a study by Keesbury and Askew (2010) which showed that majority of the cases (67%) reported in the Coast General Hospital's gender and recovery center in Kenya are of children below 14 years; and in Zambia the percentage was 49% and South Africa recorded 31% respectively. In spite of the

fact that children and youth are the primary service seekers, the study revealed that most facilities lack essential capacity to offer child-friendly services such as appropriate rooms and trained providers to examine, document, manage and refer cases of child abuse; hence, this impacts quality of care provided to children.

The Community acknowledged being aware of SGBV and its profound consequences upon women's health and wellbeing but found it difficult to report to formal structures without appropriate support, particularly among adult women. Health professionals and community ascribed sexual abuse to discriminatory cultural norms, attitudes and various myths that relate having sex with either a virgin or an own child with wealth creation and cure for certain ailments. Such myths are also reported to drive sexual violence among adolescents in other parts of sub-Saharan Africa (Seloilwe & Thupayagale-Tshweneagae, 2009).

Poverty adds to the complexity of SGBV and is seen as a significant risk factor for abuse at all levels. Due to economic dependency, women enter and remain in abusive relationships for their self and family survival. Besides, poverty influences health-seeking behavior for those who need to report abuse. Findings from this study clearly show how poor women survivors of sexual violence seek medical care, face economic burden that prevent them from accessing appropriate and timely medical care. Young women from poor families are forced to engage in transactional sex in order to obtain basic needs including

food, shelter and clothes, and this puts them at increased risks of sexual abuse. In some instances, young girls see transactional sex as a “normal” part of sexual relationships for them to live modern and luxurious life (Wamoyi et al., 2008; Samara, 2010; Rogan et al., 2010).

Due to the complexity nature and lifelong effect on women, care for SGBV survivors is important. However, subjects of the study had identified various challenges that prevent survivors from accessing appropriate care from the existing formal support structures particularly health care facilities. These factors are the results of socio-cultural practices and systematic failures of district health systems i.e. the structural factors.

The socio-cultural factors among others are discriminative cultural practices; stereotyped gender norms and the low status of women among most of coastal communities. Through the discussions and interviews, it is observed that most of the barriers encountered by survivors of SGBV in the process of reporting the abuse to formal structures were reinforced by overwhelming stigma and denial that community expressed to women survivors. Moreover, there is existence of some sexual violence stereotypes particularly in the interpretation of SGBV as expressed by more than half of the subjects of the study. The majority of people were biased by the environment of the abuse, the survivor- perpetrator relationship and the personality and life style of the survivor. To them, a woman's attire and alcohol use are considered as inappropriate behavior which put women at risk of violence.

Feelings of guilt and self-blame are common among survivors, however, GBV is never the fault of the survivor. Survivor's choices and decisions on whether to seek support or not is highly influenced by community reactions towards the abuse. Whenever a survivor faces discrimination, rejection and shame it is unlikely for them to disclose and seek support and other opportunities open to them.

Moreover, feelings of shame and fear of rejection may influence survivors' ways of life after abuse, this include where to live, what to do and whom to associate with. A report on Pursuing Justice for Sexual and Gender based Violence (ACORD – Agency for Cooperation and Research in Development, 2010) noted that survivors of SGBV suffer long term self-stigma and lose confidence and self esteem and this consequently, hinders their social and psychological development. Furthermore, in their studies, Ahrens et al. (2007) showed the relations between community reactions and survivor's health.

Negative reactions such as stigma, blaming and rejection disturb the victim's psychological adjustment and physical recovery. On the other hand, various studies have associated the survivor's actively seeking help from formal structures with positive community support/reactions (Muganyizi, 2010; Ahrens et al., 2007). According to them, when health care providers engage survivors with empathy, initiate the disclosure on the other hand, and community provide emotional support, there is likelihood for survivors to use the services.

Some cultural practices in this community continue to reinforce a belief in women's submissive roles; "mwali" traditions among Wakwere and Zaramo tribes and "Mkuki" among Masai/Wakwavi tribes. These cultural practices have long been associated with increased women's inferiority position to men in sexual matters. While the menarche girl "mwali" is secluded and trained on domestic roles as future wife and mother, a Masaai woman marries not just to her husband but the entire age group, and men are expected to surrender their bed to their visiting age-mate guest, however this practice is diminishing.

Limited knowledge and awareness among women about their fundamental rights, particularly right to live free from violence and to seek immediate health care in case of the abuse, coupled with social stigma and erosion of self esteem were also identified as barriers to access to comprehensive medical care. Lack of knowledge on where to get support and the procedures to follow while seeking medical care particularly between the health facility and police station significantly influences survivor's decision to seek support. Moreover, a lack of knowledge about the recommended 72-hour window period for seeking care in the aftermath of abuse and long distance to health care facilities may also reduce the survivors' chances of seeking health care (McClearly-Sills et al, 2012; Harris and Freceero, 2011; Muganyizi, 2010).

The requirement for a survivor who report GBV to obtain a PF3 is not clear among community in Kibaha district. The law gives survivors of violence the right to report to any nearby facility that offer GBV services including health facility and be treated without making a prior police statement (McClearly-Sills

et al., 2012). A survivor may report to the police after the emergency medical care on their consent; and in case the survivor reports to the police station first, they should from there proceed to a health care facility. A widespread belief among the community is that the survivor of violence should report to police to obtain a PF3 first before they receive medical care. This is proving difficult given the level of harassment and mistreatment most survivors report going through in the hands of the police. Women survivors have reportedly faced sexual abuse and other indecent comments that limit their willingness to approach the police. Various studies on the same have documented the failure of police and health care providers to address the immediate needs of sexually abused women in the process of seeking support which is also described by as second rape, injury or victimization (McClearly-Sills et al., 2012; Muganyizi et al., 2011).

A lack of economic empowerment among women survivors of sexual and gender-based violence and poverty was also reported to constraint women in not only accessing and affording the expenses of care, but also leave women and children to be the most victims of SGBV among Kibaha communities. It is revealed that, low economic status of individual woman increases adult women and young girls' vulnerability to prostitution in order to solicit financial and material support for their survival, and ultimately become victims of sexual violence. These findings are confirmed by previous studies done in other parts of Tanzania that show clear connections between sex and economic survival for young women which are basically entrenched in disadvantaged positions, lack of opportunity and poverty (Fuglesang, 1997; Abeid, 2015; Muganyizi, 2010;

Wamoyi et al., 2010; Plummer and Wight, 2011; Pieter et al., 2010). Additionally, the low economic status of women is evident in limiting women from utilizing the services offered at health care institutions particularly when there are substantial costs that survivors are required to incur in order to access services. These include the transportation costs to higher-level facilities particularly Tumbi One stop center that is far from most wards in KDC.

Inaccessibility of services is another factor that constraint women survivors from accessing medical care. An availability of health care facilities in close proximity increases services utilization by survivors of SGBV; however quality of care and comprehensiveness of services influences survivor decision to utilize the existing facilities in the immediate environment. However, cost, distance, inadequate services and low quality of care were perceived by subjects of the study as barriers to care seeking and reporting. Due to scarcity of health facilities that offer comprehensive clinical care, SGBV survivors are compelled to travel long distances and participants perceive this as a major hindrance to obtaining appropriate and timely care. Seeking medical care was considered as an extra financial burden as they would need to find more money meet the service costs, transportation and money for other essentials like lunch and anyone accompanying the survivor.

Despite perceptions of having appropriate structures for medical management of survivors, health care managers and providers acknowledged structural challenges that act as barriers to the access to quality and comprehensive health

care among survivors of sexual violence. It is noted that there are problems in availability of key resources such as finance, material and human resources as well as information. Additionally, the governance of the facilities also lack in-built mechanisms to guarantee continuity and allow stakeholder participation.

The findings of the study therefore, reveal the inefficiencies within the district health systems. Majority of primary health facilities lack the capacity to offer basic and emergency care for survivors of SGBV.

For instance, only two out of 26 health care facilities (Magindu dispensary and Mlandizi health center) offer clinical management for survivors; however they lack basic resources to provide the comprehensive care as required by the guideline (MoHSW, 2011). Through the established referral systems, all complicated cases and survivors who need some additional services are referred to OSC which is situated in Tumbi regional referral hospital for specialized care. Literally, the OSC is expected to give access to holistic services to survivors including health, psychosocial support, legal and police services under one roof in order to not only improve care and support to survivors but also to meet their best outcomes. However, it is observed that the OSC at Tumbi lack sufficient resources particularly infrastructure and supplies to offer SGBV related services to survivors. The OSC does not offer all services under one roof as SGBV survivors receive police services, trauma counseling and continued psychosocial support at the OSC and are referred to different departments within the facility for clinical care, but due to existing workloads, doctors who have many other duties, may be overworked, not available when needed, and less likely to fully

document cases (Keesbury and Skew, 2010). The OSC does not offer 24 hours police and psychosocial services; also it is far from most of wards in Kibaha.

A lack of women-centered care: the existing health systems in Kibaha do not offer women-centered care which ensures that a woman survivor is fully informed and gives consent, her dignity is respected and her confidentiality guaranteed and most importantly is sensitive to her needs and perception. None of the facilities have got a quiet and spacious or private room for GBV services that will ensure privacy and confidentiality to clients. Also, the frequent stock outs of essential medicines and medical supplies to offer the minimum standard of care to survivors such as rape kits for collection of forensic evidence, supplies and equipment for preventing and controlling infections, test kits for pregnancy and VDRL as well as some medications for treatment of STIs significantly reduces the quality of services provided to women survivors of SGBV.

Moreover, the capacity of providers was revealed as the key barrier to quality and comprehensive care to survivors of SGBV. There is an acute shortage of trained healthcare providers who know the proper procedures on SGBV responses such as collection of forensic evidence, conducting safety plans, adherence to privacy and confidentiality and making referrals of survivors to other service providers at both low level facilities and OSC. In spite of their roles in ensuring the availability of skilled human resources for health in all facilities, findings from this study reveals less efforts of Health management teams to conduct trainings –both on job and short courses in response to SGBV.

According to service providers, the last training was conducted by partner organizations (Plan International) in collaboration with KDC in 2013 and it involved selected health care providers from each facility. However, due to the frequent reshuffling of healthcare providers, some facilities have remained with no skilled providers-such as Magindu dispensary and others – such as Kwala dispensary- has remained with only one -but who is also the facility in charge. A lack of proper training may reduce providers' capacity to recognize signs of violence, and respond appropriately and in gender-sensitive manner that aids survivors' recovery from the traumatic consequences of the abuse. This shortage of staff generates unnecessary long waiting times which discourages survivors and is likely to reduce the standard care that health care providers would like to offer or as is expected of them.

Quality of care is also affected by negative attitudes of providers towards survivors of SGBV. Since they come from same community, many service providers including the police, doctors, nurses, social welfare officers hold the stereotyped attitudes towards survivors. These misperceptions about survivors not only reinforce stigma, shame, and victim-blaming but also violate survivor's right to be treated with respect and in a non-discriminatory ways.

Studies from most sub-Saharan countries have documented this problem of shortage of skilled human resources for health (Kurowiski et al., 2007; WHO, 2006).

Furthermore, a study in Uganda and Rwanda reported preference of survivors and their families for resolving the SGBV cases at home so as to avoid shame and stigma from the public; a lack of awareness of existing formal support structures and the procedures involved while seeking medical care; inability to pay for substantial costs; long distance to the support delivery and threats by the perpetrator among the key challenges to access to medical care by survivors. Additionally, the prolonged and inefficient procedures, and unfriendly police and health care providers discourage survivors from seeking help (Elson, Lynne and Keesbury, 2010). Limited space in both OSC and health facilities was reported to hamper confidentiality and privacy of consultations and examinations; and also stigma-related fears make SGBV survivors shun hospital settings (Munalula & Kanyengo, 2011; Undie et al., 2012).

There is also poor documentation and record keeping at health facilities and OSC in the district. Almost all facilities in KDC lack tools for documentation of client records such as client's name and address. Instead of standardized forms, client's information is recorded on counter books. Surprisingly, there are Computers and fax machines at OSC but none of them is working and also Plan International had donated a standby generator for the OSC, but it has not been installed as at the time of the interview.

Through the decentralization of health systems, Tanzania has given the Council Health Management Team (CHMT) mandate to supervise health services provision in its district, thus ensuring the availability of key resources that meet

community demands. In response to GBV, CHMT is expected to guide advocacy for increasing resources for GBV activities, improving coordination, and ensuring the sustainability of GBV services at all levels of services delivery point. However, findings from the study revealed a lack of effective GBV plans in the district.

There is an absence of effective follow up mechanism from local authorities (Kibaha district council and Town council) and the police stations (gender desk). Moreover, community sensitization has not been done effectively. People do not have the right information on the existence of OSC, what services they may get from the center and the procedures to follow while seeking for services. Furthermore, there are ineffective Community structures to respond to GBV at all levels (e.g., Village/Ward Social Service Committee, Village/Ward Social Security Committee, drop-in centers and shelters, faith-based organizations, and police posts/stations) and this jeopardizes security to the survivor.

5.3 Summary

This study has examined the experiences of women survivors of sexual violence and challenges they face in seeking medical services in Kibaha district. In particular, the study has looked at the lived experiences of women survivors of SGBV both negative and positive and the challenges which act as barriers to both seeking medical care and reporting the abuse in the existing formal structures in three wards of Magindu, Mlandizi and Kwala.

SGBV was clearly perceived as a serious problem in Kibaha that is increasing in intensity; and physical, intimate partner violence, early marriages and early pregnancies are other forms gender-based violence which are common among Kibaha communities. In terms of the nature and sphere of SGBV in the district, it is revealed that most of the sexual violence acts happen in both public and domestic spheres and women are seen as the main victims as compared to men; although young boys may also be victims of sexual assault among coastal communities.

Having a gender perspective in access to medical care is important because it has helped to highlight how culture through discriminative gender norms interacts with the environment to reproduce cultural inequalities between men and women who, through stereotypical roles, legitimize or aggravate violence hence deter women survivors from accessing medical care particularly in patriarchal-minded health institutions.

Understanding of the ways people experience and perceive SGBV and respond to the services they receive and how they individually cope with their lives aftermath the abuse has been important in this study as it has exposed the hidden gaps in health services delivery and potential barriers to care in rural settings and the plight of women survivors of sexual violence; and recommending proper ways of improving rural health care system that will not only end SGBV, but also attract more rape victims to seek healthcare as well as prescribing how the survivors can be compensated and supported accordingly.

By using phenomenology theory, it has been realized that perceptions of individuals, family, community and society at large have effects on women help seeking behavior and overall access to medical care. Economic vulnerability and dependency of women on men also intensify their inability to meet the substantial costs of services thus preventing them from accessing appropriate and timely care.

Moreover, limited knowledge on women's rights to life free of violence and to seek immediate health care; coupled with social stigma and erosion of self esteem were also identified as barriers to access to comprehensive medical care. On the other hand, limited medical care services especially in rural areas in terms of physical availability of services, insufficient resources both human, material and the impact of services to survivors (Health outcomes) are some structural factors that hamper women's access to quality medical care. Inadequate working space at health facilities; frequent stock outs of medicines and supplies i.e. medical and administrative; and high costs of services contributes to this insufficiency in handling survivors of sexual and other forms of gender based violence in Kibaha district.

5.4 Conclusion

Sexual and gender-based violence among women and girls is the most common form of GBV in Kibaha district; however the majority of adult women rarely report the abuse to the formal structures including health facilities. This study has shed light on the various social and gender norms that support sexual

violence against women and young girls in Kibaha district. It has also identified a variety of prominent socio-cultural and structural barriers, such as stigma, fear of blame and shame for disclosing abuse, and insufficient and costly medical services, each of which act as barriers to the access to comprehensive health care for women survivors of sexual violence.

The nature of sexual and gender-based violence and the stigma associated with it calls for the need to institute effective ways of identifying survivors and the appropriate support that they need and most importantly, the compensation where applicable of the harm inflicted on the individual. The compensation must be within the lawful processes instead of the many kangaroo based courts that are set up in the villages to hide the heinous acts that women are subjected to.

The field study revealed the existence of normative social environment that contributes to the highest levels of sexual violence acceptance attitudes among women themselves as well as at the societal level at large. This challenge is highly contributed to by a lack of community understanding of what constitute sexual violence and women's rights. Considering that most survivors are women or girls, the process of empowering women and increasing the community knowledge on SGBV and women's rights can aid in changing people's perceptions and attitudes towards sexual and gender-based violence and women as the main victims.

Failure of the district officials to prioritize the SGBV issues and allocate sufficient resources has got serious implications on the district's SGBV responses. Adequate resources and supervision could mitigate some factors that act as barriers to services delivery and the improvement of health care provider's productivity, timely availability of medicines and supplies which will eventually improve the quality of services.

5.5 Recommendations

From the above findings, this study recommends the following steps so as to improve both quality of care and survivors' access to health care:

- Improvement of healthcare response to SGBV is critically important. This includes support for the training of health care workers, protocols, and ensuring that adequate availability of supplies for caring of survivors of SGBV in both selected health facilities that offer GBV services and OSC.
- OSC should stand by its own, in terms of budgets, 24hrs staffs, and its own management. This will speed up decisions and improve services to survivors.
- KDC should initiate Multi-sectoral responses to SGBV particularly those which aim at improving women's lives through economic empowerment and social service improvement.. There is also the need to develop sustainable public-private partnership as mutual player in improving health service delivery and justice to survivors..

- SGBV survivors, especially children, may be intimidated and threatened so that they may fear reporting the incident. It is important for community, family, and healthcare providers to create safe spaces for survivors of violence and have mechanisms that will ensure security of survivors and their ease of access to care.
- KDC and other stakeholders should come up with effective community awareness programs with the aim of educating community on gender-based violence including laws related to SGBV as well as existing support systems and its importance on women's health.
- Communities should also be informed and empowered to prevent and respond to GBV by advocating adherence to basic human rights principles, gender equity, rights of women and children, justice, and elimination of the negative cultural practices inherent in the communities.
- The help seeking procedures particularly the requirement of obtaining PF3 should be clarified to all actors that a survivor may come into contact with while seeking medical care, including police, health care providers, community leaders and social welfare officers among others.

- There is need for the prohibition of discriminative cultural practices that perpetuate GBV and enforcement of laws and policies on women rights and GBV so as to reduce the occurrence of and tolerance for violence against women.

REFERENCES

- Abeid, M. (2015). *Improving Health Seeking Behavior and Care among Sexual Violence Survivors in Rural Tanzania*. Uppsala: Acta Universitatis Upsaliensis. 2015
- Adams, J. A, Girardin, B., Faugno, D. (2000). *Signs of genital trauma in adolescent rape victims examined acutely*. *Pediatric Adolesc Gynecol*. 2000 May; 13(2): 88
- Amaya, Claudia Elizabeth Gonzalez, Arun Kumar Acharya, and Jose Maria Infante Bonfiglio. (2016) "Gender Based Violence and Reproductive Health of Indigenous Women in Mexico", *Sociology Mind*.
- B. Gelaye. "Correlates of Violent Response Among Peruvian Women Abused by an Intimate Partner", *Journal of Interpersonal Violence*, 01/01/2010
- Baelani I, & Dunser MW., (2011). "Facing medical care problems of victims of sexual violence in Goma/Eastern Democratic Republic of the Congo". *Conflict and Health*, 2011
- Bates, L. M, Hankivsky, O. and Springer, K. W. (2009). Gender and health inequities: a comment on the final report of the WHO commission on the social determinants of health. *Soc Sci Med* 2009, 69:1002–1004. 31.
- Beaulaurier, R. L, Newman, L. F. & Seff, R. L. (2008). A descriptive model on Barriers to help-seeking domestic violence survivors. *Women and Aging*, Vol 20 (2-3). The Haworth Press
- Betron, M. (2008). *Gender-based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions*. Washington, DC: Futures Group, Health Policy Initiative, Task Oder 1.
- Bott, S., Morrison, A. & Ellsberg, M. (2005). *Preventing and responding to Gender-based Violence in middle and low income countries: a global review and analysis*. In: *Worldbank* (ed). New York: Worldbank, 2005.
- Brown, A. & Widney. (2001). "Obstacles to Women Accessing Forensic Exams In Cases Of Sexual Violence". Unpublished Background Paper to the Consultation on the Health Response To Sexual Violence, WHO headquarters, Department of Injustices and Violence Prevention and Gender and Women's Health, Geneva, June 2001. Available at: www.hrw.org/backgrounder/wrd/who-bck.pdf
- CARE, "One-stop Model of Support for Survivors of Gender-based Violence: Lessons from Care Zambia" (CARE, 2013)
- Campbel R, Ahrens CE, Sefl T, Wason SM, Barnes HE. *Social reactions to rape victims: healing and hurtfuleffects on psychological and physical health outcomes*. *Violence Vict* 2001; 16(3):287-302

Connell, R. (2012). Gender, health and theory: Conceptualizing the issue, in local and world perspective. *Soc Sci Med* 74:1675–1683.

Connell, R. (2009). *Gender: In world perspective*. Cambridge: Polity.

Country Report for the Beijing Platform for Action after 20 years (The Beijing +20). Ministry of Community Development, Gender and Children, Dar es Salaam; and Ministry of Empowerment, Social Welfare, Youth, Women and Children Development, Zanzibar; 2014.

E. Fulu, A. Kerr-Wilson, and J. Lang (2014), “Effectiveness of interventions to prevent violence against women and girls: A summary of the evidence” in *What Works to Prevent Violence* (UK Aid, Sexual Violence Research Initiative).

Elson, Lynne and Jill Keesbury, (2010). “PEPFAR Special Initiative on Sexual and Gender-Based Violence: Baseline Report”. Lusaka: Population Council.

Freccero J, Harris L, Carnay M, Taylor C. (2011). *Responding to Sexual Violence: Community Approaches*. Sexual Violence & Accountability Project Working Paper Series. University of California, Berkeley.

Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts, C. H. (2006). Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet*.

Harris L and Freccero J, (2011). *Sexual Violence: Medical and Psychosocial Support*. Sexual Violence & Accountability Project Working Paper Series. University of California, Berkeley, 2011.

Heise, L. L. (1998). "Violence Against Women: An Integrated, Ecological Framework,"

HDT, (2011). *Gaps in Policies and Laws That Perpetuate Gender Based Violence in Tanzania; An Analysis and Synthesis*. Human Development Trust.

Hycner, R H (1985) "Some guidelines for the phenomenological analysis of interview data," *Human Studies* 8, 279-303

Jackson, C (1996). 'Rescuing gender from the poverty trap', World Development.

Keesbury, J. and I. Askew. (2010). *Comprehensive Responses to Sexual Violence in East and Southern Africa: Lessons Learned from Implementation*. (Lusaka: Population Council).

Keesbury, J., Onyango-Ouma W, Undie, C, Maternowska, C, Mugisha, F, Kageha, E, and Askew I. (2012). *A Review and Evaluation of Multi-Sectoral Response Services (—One-Stop Centers) for Gender-Based Violence in Kenya and Zambia*. Population Council: Nairobi, Kenya.

Kisanga F, Nyström L, Hogan N, Mbwambo J, Lindmark G, Emmelin, M. (2010): Perceptions of Child Sexual Abuse—A Qualitative Interview Study with Representatives of the Socio-Legal System in Urban Tanzania. *Journal of Child Sex Abuse* 2010, 19 (3): 290–309.

Krantz, G., and Garcia-Moreno, C. (2005). “Violence against women” in *Journal of Epidemiology and Community Health*.

Krug, E. G, Mercy, J.A, Dahlberg, L. L, Zwi, A. B. (2002). The world Report on Violence and Health. *Lancet*, 360 (9339):1083-1088.

Kwesigabo, G, Mwangi, M.A, Kakoko, D. C, Warriner, I., Mkony, C. A, Killewo J, and Freeman, P. (2012). Tanzania's health system and workforce crisis. *Journal Public Health Policy*. 33 Suppl 1:S 35-44.

Laisser RM, Lugina HI, Lindmark G, Nyström L, Emmelin M (2009). Striving to Make a Difference: Health Care Worker Experiences With Intimate Partner Violence Clients in Tanzania. *Health Care Women Int*.

Lester, S. (1999). *An introduction to phenomenological research*. Stan Lester Developments, 1999. Taunton.

Selic P, Pesjak K, Kersnik J. (2011). The prevalence of exposure to domestic violence and the factors associated with co-occurrence of psychological and physical violence exposure: A sample from primary care patients. *BMC Public Health* 11(1): 621.

Maman S, J. Mbwambo, N. Hogan, G. Kilonzo, et al. (2002). “HIV-Positive Women Report Increased Partner Violence in Tanzania.” *American Journal of Public Health* 92 (8): 1331–1337.

Manzi, F., Schellenberg, J., Hutton, G., Wyss, K., Mbuya, K., Shirima, K. ... Schellenberg, D. (2012). Human resources for health care delivery in Tanzania: a multifaceted problem. *Human Resources for Health*: 10: 3. DOI: 10.1186/1478-4491-10-3

Mbunda, F. D. (1991): *Traditional Sex Education in Tanzania: A Study of Twelve Ethnic Groups*. Dar es salaam: WAZAZI (the Parents Association of Tanzania) and UNFPA. New York: The Margareth Sanger Centre.

McCleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Steven, E., Salvatory, A. (2012). *Help-Seeking Pathways and Barriers for Survivors of Gender-based*

Violence in Tanzania: Results from a Study in Dar es Salaam, Mbeya, and Iringa Regions. Dar es Salaam, Tanzania: Engender Health/CHAMPION.

McClearly-Sills, J, Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., and Steven, E. “Stigma, Shame and Women’s Limited Agency in Help-seeking for Intimate Partner Violence”, *Global Public Health*, 2015.

Muganyizi, P. (2010). “Rape against Women in Tanzania: *Studies of Social Reactions and Barriers to Disclosure*. Uppsala: Acta Universitatis Upsaliensis

Muganyizi, P. S, Nyström, L., Axemo, P., and Emmelin, M. (2011). Managing in the Contemporary World: Rape Victims’ and Supporters’ Experiences of Barriers Within the Police and the Health Care System in Tanzania. *J Interpers Violence* 20 (10).

Muyanga, M. (2011). *Barriers faced by women survivors of gender-based violence in seeking care: the case of Kenyatta National Hospital Gender based violence recovery centre.*

National Bureau of Statistics (NBS): (2011). *Tanzania Demographic and Health Survey 2010*. Dar es Salaam, Tanzania: National Bureau of Statistics.

National Bureau of Statistics (NBS), 2013. *The 2012 Population and Housing Census, Population Distribution by Administrative Areas (Volume I&II)*, Dar es Salaam, Tanzania.

National Bureau of Statistics (2016). *Basic Demographic and Socio-Economic Profile Pwani Region*. National Bureau of Statistics.

Oliveira, P. P, Viegas, S.M.F, Santos, W. J, Silveira, E.A.A, and Elias, S. C. (2015). Women victims of domestic violence: a phenomenological approach. *Text Context Nursing, Florianópolis*, Jan-Mar; 24(1): 196-203.

Overstreet, N. M., & Quinn, D. M. (2013). The Intimate Partner Violence Stigmatization Model and Barriers to Help-Seeking. *Basic and Applied Social Psychology*, 35(1), 109–122. <http://doi.org/10.1080/01973533.2012.746599>

Oxaal, Z and Baden, S, (1998). “Briefing prepared for the Swedish Interantional Development Co-operation”. *Health and Poverty: A Gender Analysis*, BRIDGE Institute of Development Studies, University of Sussex.

Palermo T, Bleck J, and Peterman A, (2013). “Tip of the Iceberg: Reporting and Gender-Based Violence in Developing Countries”. *American Journal of Epidemiology*. Oxford University Press on behalf of the Johns Hopkins Bloomberg School of Public Health.

Pickup F, Williams S, Sweetman, C. (2001). *Ending Violence Against Women: A challenge for Development and Humanitarian Work*. Oxfarm GB.

Prime Minister's Office, Regional Administration and Local Government (PMoRALG) (2015). *Kibaha District Investment Profile*.

Stan Lester (1999). *An introduction to Phenomenological Research*. Stan Lester Developments, Taunton.

Selic, P., Pesjak, K., & Kersnik, J. (2011). The prevalence of exposure to domestic violence and the factors associated with co-occurrence of psychological and physical violence exposure: A sample from primary care patients. *BMC Public Health*, 11, 621-631.

Siwal B.R (n.d). Empowerment of women—conceptual Framework. Retrieved from www.scribid.com

Swantz, M. (1966). *Religious and Magical Rites of Bantu Women in Tanzania*: Institute of Traditional Medicine, Muhimbili University of Health and Allied Sciences, Tanzania.

Tanzania Commission for AIDS (TACAIDS), (2012). “Child Abuse Report 2012”. TACAIDS.

Tanzania Legal and Human Rights Centre (2013). *The Proposed Constitution of Tanzania*. Dar es Salaam: Tanzania Legal and Human Rights Centre.

Tanzania Ministry of Community Development, Gender and Children (2012), Legal Capacity, (http://www.mcdgc.go.tz/index.php/issues/legal_capacity/2012).

Terry, G & Hoare J. (eds.) (2007). *Working in Gender & Development; Gender-Based Violence*. Oxfam GB.

The CHAMPION Project. (2014). Channeling men's positive involvement in the national HIV/AIDS response in Tanzania: An overview of the CHAMPION Project. CHAMPION Brief No. 1. Dar es Salaam: Engender Health/CHAMPION Project.

UNICEF (2014) *Hidden in Plain Sight: A Statistical Analysis of Violence against Children*. UNICEF.

Swantz, M. (1966). *Religious and Magical Rites of Bantu Women in Tanzania*: Institute of Traditional Medicine, Muhimbili University of Health and Allied Sciences, Tanzania.

United Republic of Tanzania, Ministry Of Health and Social Welfare. (2011). *National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (SGBV)*. Tanzania.

United States Agency for International Development (USAID) (2008). Gender-based violence in Tanzania: An assessment of policies, services and promising interventions 2008. [<http://www.mcdgc.go.tz/data/PNADN851.pdf>]

UN women, (2013). “Facts and Figure: Ending Violence against Women”

UN Women (2013). Safe Cities Global Initiative Brief. Available at: <http://www.unwomen.org/En/what-we-do/ending-violence-against-women>. United Nations.

United Nations Economic and Social Affairs (2015). *The World’s Women 2015, Trends and Statistics*.

UNODC (2014). “Global Report on Trafficking in Persons”, p. 5, 11. (United Nations publication, Sales No. E.14.V.10.

U.S. Department Of State, (2010) *Human Rights Report: Tanzania*

IGWG of USAID. (2006) “Addressing gender-based violence through usaid’s health programs: A guide for health sector program officers.” Washington, DC.

Watts, C., Heise, L., Ellsberg, M, and Moreno G. (2001). *Putting Women first: Ethical and Safety recommendations for research on domestic violence against women*. Geneva: World Health Organization.

United Nations, (2013). “Violence against women, chapter 6”.

Williams CM, McCloskey LA, Larsen U, (2008). “Sexual Violence at first intercourse against women in Moshi, northern Tanzania: prevalence, risk factors and consequences”. *Popul stud (Camb)* 2008;62(3): 335-48.

WHO (2005). *Multi-country Study on Women’s Health and Domestic Violence against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women’s Responses* (Geneva: World Health Organization).

World Health Organization. (2009). *Monitoring and Evaluation of Health System Strengthening: An Operational Framework*. Geneva.

World Health Organization (2013). “Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence, p.2.” UNDP, UNFPA, UN Women and UNV.

World Health Organization (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. WHO.


World Bank (2012). World Development Report 2012 - Gender Equality and Development. Washington, DC: World Bank.

APPENDICES**Appendix I: Research Plan**

ACTIVITY	MONTH		
	MARCH – JUNE	NOVEMBER	DECEMBER
Problem Identification			
Review of Literature			
Questionnaire Development			
Questionnaire Pre-testing			
Data Collection			
Data Analysis			
Report Writing, Submission & Presentation			

Appendix II: Research Permit

**TANZANIA COMMISSION FOR SCIENCE AND TECHNOLOGY
(COSTECH)**




Telephones: (255 - 022) 2775155 - 6, 2700745/6
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Ali Hassan Mwinyi Road
 P.O. Box 4302
 Dar es Salaam
 Tanzania

RESEARCH PERMIT

No. 2016-366-NA-2016-300 23rd November 2016

1. Name : Aisha Hamis Mkumbipolly
2. Nationality : Tanzanian
3. Title : "Experiences of Women Survivors of Sexual Violence in Seeking Medical Care in Kibaha District, Coast Region, Tanzania"
4. Research shall be confined to the following region(s): Coast
5. Permit validity from: 23rd November 2016 to 22nd November 2017
6. Researcher is required to submit progress report on quarterly basis and submit all Publications made after research.


 M. Mushi
 for: DIRECTOR GENERAL



Appendix IV: In-depth interview guide**SECTION ONE: Demographic profile of the Informants**

Informant's CODE: _____

1. Age of a woman SGBV survivor
 15 – 20 12 – 30 31 – 40 41 – 49
2. Marital Status
 Single Married Divorced Widowed
 Separated Others (specify)
3. Level of education;
 No formal education Primary education Ordinary secondary level
 Advanced secondary level Tertiary level
4. Occupation
 Government employed Employed in Private sector Farmer
 private business owner Unemployed others
(specify)
5. Number of Children/dependents
 less than 2 2-5 5-8 more than 8

SECTION TWO: Experience of women SGBV survivors in accessing health care

1. What do you understand by the term “Sexual Violence”?
2. Which forms of sexual abuse are common in your community?
3. When the abuse occurred? (probe on survivors relationship with the perpetrator, the environment that violence occurred)
4. Where did you report/seek medical care? (Probe on survivor's awareness on the sources and procedures for seeking medical care in case of violence?)
5. How were you treated/ handled at the source of help? (Probe the type of services inline with Good interpersonal relations – treated with respect, Individual counseling, Post-traumatic and Adherence counseling, Pre- and post-test HIV counseling, Linked/referral with other SGBV services and Follow up services)
6. Any problems you faced at the reporting medical facility? (probe on satisfaction on “quality” and the “availability” of the services and support provided)
7. How has the community treated you since then?
8. Did you face any financial/ economic problems?
9. How have you coped since the abuse?
10. Is there enough family/ community support?

Appendix V: Key Informant Interview Guide with Service Providers

1. Je, kituo hiki kinatoa huduma gani za matibabu kwa waliopatwa na UWAKI? (Dodosajuu ya Utambuzi wa waliopatwa na uwaki, kuchukua historia, ukusanyaji wa sampuli na vipimo, vya maabara, dawa za dharura (VVU, mimba, STDs); unasihi; rufaa na ufuatiliaji wa mgojwa)
2. Rasilimali zilizopo za kutolea huduma kwa waliopatwa na UWAKI
 - Rasilimali watu (je, wamepatiwa mafunzo maalum ya UWAKI)
 - Vifaa tiba
 - Vitengo/Vyumba vya kutolea huduma vilivyopo: RCHC/OPD/CTC (Angalia usiri wa huduma)
3. Idadi ya waliopatwa na UWAKI wanaohudumiwa katika kituo hiki (Jinsia, Umri, mahali wanapotokea)
4. Kwa mtazamo wako, ni asilimia ngapi ya wanaopatwa na UWAKI hutafuta huduma za matibabu? Fafanua jibu
5. Ni jinsi gani imani za kiutamaduni (cultural norms) zinachangia UWAKI hususan ukatili wa kingono ndani ya halmashauri ya Kibaha? (dodosa juu ya sababu nyinginezo, na ikiwezekana **cultural justifications**, zinazopelekea jamii kuridhia vitendo hivyo)
 - Imani hizi zinaathiri vipi wanawake kutokutafuta huduma za matibabu baada ya UWAKI
6. Kuna changamoto gani zinazokabili vituo vya huduma za matibabu na msaada kwa wanawake wahanga wa ukatili wa kingono? (dodosa kuhusu miundombinu, rasilimali watu, fedha, vifaa tiba, muitikio wa kijamii, utamaduni nk) .
7. Kwa maoni yako, nini kifanyike ili kutatua changamoto hizo?

Appendix VI: Key Informant Interview Guide with District Medical Officer/Gender Focal person.

1. What is your understanding of sexual abuse?
2. Common forms of sexual abuse prevalent in KDC
3. Have you ever heard of any case of women or children in this community who have been raped or forced to have sex? Yes / No
4. How does cultural norms influence occurrence of SGBV against women in KDC? (**Probe** on the causes and if possible, the cultural justifications for violence, societal acceptance etc)
5. Do women or children look for help when this happens to them? Yes / No
 - a. If yes, where do they go?
6. What services does the district offer to survivors. (**Probe** on availability of medical services, staff attitudes and perceptions of affordability, and cultural adaptability among others).
7. What are the potential constraints faced by survivors in existing health care and support systems? (**Probe** on the infrastructure, availability of medical care, availability of personnel, friendly services etc).
8. How best could the problem be addressed? (**Probe** on their own thinking on the issue, attitudes towards the existing medical services etc).

Appendix VII: Key Informant Interview Guide with CSO representative**Aina ya shirika:** _____ **Eneo la kiutendaji:** _____**Muda shirika lilipoanza kufanya shughuli zake:** _____

1. Je, shirika lako linatoa msaada gani kwa wanawake waliopatwa na ukatili wa kijinsia? (dodosa huduma za matibabu na idadi/asilimia kwa Jinsia, Umri, mahali wanapotokea)
2. Kwa mtazamo wako, ni asilimia ngapi ya wanaopatwa na UWAKI hutafuta huduma za matibabu? Fafanua jibu
3. Ni jinsi gani utamaduni (cultural norms) unachangia vitendo vya ukatili wa kijinsia hususan ukatili wa kingono ndani ya halmashauri ya Kibaha? (dodosa juu ya sababu nyinginezo, na ikiwezekana **cultural justifications**, zinazopelekea jamii kuridhia vitendo hivyo)
4. Je, mnashirikiana vipi na watoa huduma wengine wanaohudumia wanawake waliopatwa na UWAKI katika kusaidia wahanga hao kupata huduma bora? (Halmashauri/AZAKI/kamati za UWAKI/kata/vijiji/mitaa/wengineo)
5. Kuna Changamoto zozote mnazokumbana nazo katika kutoa huduma hizo?
6. Kwa maoni yako, nini kifanyike ili kutatua changamoto hizo?

Appendix VIII: Case Narrative Guide

Please provide answers to the following:

- Kind of sexual abuse experienced and events surrounding it (when, how and where did it happen)
- Knowledge of the perpetrator and kind of relationship
- Where was the medical report of the incidence made? (Time taken after the event, type of services received, quality of services, service satisfaction)
- Cultural and economic barriers experienced in seeking medical care
- Life after abuse and community perception